Providence Health Plan

PO Box 4649, Portland, OR 97208-4649

2024 Washington Individual & Family Change Form

This form is for **current Providence Health Plan Individual & Family Policyholders**. Changes to your Providence Health Plan coverage can **only** be requested by the Policyholder. To complete an application for new enrollment, please visit **ProvidenceHealthPlan.com/Shop** or call our Sales team at **503-574-5000** or **800-988-0088 (TTY: 711)**.

To fill out and submit a change form online, visit **ProvidenceHealthPlan.com/INDChange2024**.

Requesting changes to my policy

Keep in mind that some changes require a Qualifying Event. Experiencing a Qualifying Event grants you a 60-day Special Enrollment Period to make changes to your policy by submitting this change form. You may also use this form to report or correct your policy information without experiencing a Qualifying Event. Please see the "Make Changes to Your Plan" section for a list of Qualifying Events to determine if the change you want requires one.

When will my change(s) go into effect?

This form is for changes effective January 1, 2024 through December 31, 2024. For all Qualifying Events and changes, coverage will be effective the first day of the month following the receipt of your completed change form as long as we receive your form **within 60 days** of the Qualifying Event.

Please refer to the example effective dates table below.

DATE WE RECEIVE YOUR CHANGE FORM:	EFFECTIVE DATE OF CHANGE:
March 1 - 31	Your change will be effective **April 1**.
April 1 - 30	Your change will be effective **May 1**.

Please note: If you have an active recurring payment arrangement with Providence Health Plan, any changes to your premium rate may not update prior to when your recurring payment is processed. If your request results in a lower premium, your account will be credited on your next month's invoice. If your request results in a higher premium, Providence Health Plan will bill you for the additional amount.

Termination of your medical coverage will be effective on the last day of the monthly period through which your premium was paid at the time this form is received.

If the Qualifying Event is birth, adoption, placement for adoption or foster care of a child, or a court order, coverage will be effective from the date of the event. If you would instead prefer a prospective (coverage) effective date based on the table above, please clearly indicate this on your form.

Please review the form to check that you've finished filling out all the required sections. If this form is incomplete for any reason—if it's missing Policyholder information, a valid signature by the Policyholder, Qualifying Event, etc.—or if additional information is required, this may delay or void your requested changes. Your change form will expire **60 days after** the signature date.

DO NOT RETURN THIS PAGE TO PROVIDENCE HEALTH PLAN

Policyholder Information

This section needs to be completed for all plan change and cancellation requests.
If this information is incomplete, your change form may be returned, causing a delay.

LAST NAME _____ FIRST NAME _____ MI _____

SUBSCRIBER ID NUMBER _____ SOCIAL SECURITY NUMBER ___ – ___ – _____ DATE OF BIRTH (MM/DD/YYYY) ___/___/_____

GENDER: ☐ Male ☐ Female ☐ Other

HOW DO YOU IDENTIFY? (These fields are optional. Your response will help us to better serve all communities.)

☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

PHYSICAL ADDRESS (NO P.O. BOX OR RETAIL/BUSINESS ADDRESSES) _____ ☐ This is a new address

CITY _____ COUNTY _____ STATE _____ ZIP CODE _____

MAILING ADDRESS (IF DIFFERENT FROM PHYSICAL ADDRESS) _____ ☐ This is a new address

CITY _____ COUNTY _____ STATE _____ ZIP CODE _____

HOME/CELL PHONE _____ WORK/OTHER PHONE (OPTIONAL) _____ EMAIL ADDRESS _____

Have you used any tobacco products in the last six months? ☐ Yes ☐ No
(Tobacco use is defined as an average of at least four times a week, except for religious or ceremonial purposes.)

Option 1: Cancellation

Complete this section only if you want to cancel your Individual & Family Plan coverage.

☐ I want to cancel my Individual & Family Plan coverage.

Checking this box will end the health insurance coverage for all enrolled members on your plan. Termination of your medical coverage will be effective on the last day of the monthly period through which premium was paid at the time this form is received.

Sign, date, and submit only this page to complete your request to cancel your coverage.

Signature is considered valid only if it is handwritten ("wet") or e-signed.
A copy of legal guardianship or power of attorney must accompany this form if not signed by the Policyholder.

SIGNATURE OF POLICYHOLDER, LEGAL GUARDIAN OR POWER OF ATTORNEY _____ TODAY'S DATE (MM/DD/YYYY) ___/___/_____

Option 2: Make changes to your 2024 plan

Select one or more changes you want to make to your plan.

I want to make the following change(s) that don't require a Qualifying Event:

- ☐ Remove dependent(s)
- ☐ Report changes or corrections to a member's personal information (i.e., name, birthdate, tobacco status, etc.)
- ☐ Change my address after moving within the same service area:

  _____ /_____ /_____
  DATE OF MOVE (REQUIRED)

If you only have changes that DO NOT require a Qualifying Event, continue to "Change Information for My Dependents" on page 4.

I want to make changes after having experienced a Qualifying Event:

- ☐ Change my medical plan
- ☐ Add dependent(s)

Date of Qualifying Event: _____ /_____ /_____

Name of family member who experienced the Qualifying Event: _____

Select the Qualifying Event:

- ☐ Involuntary loss of individual or group coverage except for failure to pay the premium
- ☐ Marriage or state registered domestic partnership*
- ☐ Birth, adoption, placement for adoption or foster care of a child
- ☐ Qualified Medical Child Support Order (QMCSO) or acquisition of legal guardianship
- ☐ Permanent move to a new Providence Health Plan service area that offers different health plan options
- ☐ Loss of coverage as a dependent due to age
- ☐ Loss of coverage due to end of marriage or state registered domestic partnership*
- ☐ Involuntary loss of Medicaid or CHIP coverage
- ☐ Newly eligible for a state- or federally-sponsored premium assistance program
- ☐ Loss of Advance Premium Tax Credit (APTC), Cost Sharing Reductions (CSR), or cessation of employer contribution to COBRA
- ☐ Newly gains access to an individual coverage HRA (ICHRA) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA)
- ☐ Survivor of domestic abuse/violence or spousal abandonment and wants to enroll in a health plan separate from the abuser or abandoner

Providence Health Plan must receive your completed change form and required documentation **within 60 days** of your Qualifying Event. Refer to **ProvidenceHealthPlan.com/QE** for additional information regarding Special Enrollment Periods.

*"State registered domestic partners" means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030, and who have been issued a certificate of state registered domestic partnership by the secretary.

Choose a new medical plan:

Changing your medical plan outside of Open Enrollment requires a Qualifying Event. To make the following changes to your medical plan, check one box below. If there are no changes, leave this section blank.

You can learn more about each of the medical plans listed below by reading their corresponding Summary of Benefits and Coverage (SBC) at **ProvidenceHealthPlan.com/SBC**.

Applicable Counties	Network	Medical Plan (Check One)
Benton, Clark, Franklin, Spokane, Thurston, Walla Walla	**Choice**	☐ Columbia 1500 Gold ☐ Columbia 5000 Silver ☐ Columbia 8900 Bronze

You'll need to choose a Medical Home and a Primary Care Provider (PCP) after you enroll. Find an in-network provider at **ProvidenceHealthPlan.com/FindAProvider**.

Pediatric Dental Disclaimer: Our medical plans DO NOT include pediatric dental coverage. Under the health care reform law (the Affordable Care Act or ACA), if you purchase one of these plans outside of the Exchange, we must have reasonable assurance that you have obtained separate pediatric dental coverage through an Exchange-certified pediatric dental plan. This requirement applies whether you obtain coverage for children or adults. Exchange-certified pediatric dental plans can be found through the Washington Health Benefit Exchange at **WaHealthPlanFinder.org**.

Change Information for My Dependents

Only changes reflected on this form will be updated on your plan. If you are not making any changes, leave this page blank. Adding a dependent outside of Open Enrollment requires a Qualifying Event. Make sure you use full, legal names. For all plans, dependent children must be age 25 or younger as of their effective date.

1 **CHECK ONE:**

☐ **Add**
☐ **Remove**
☐ **Update**

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ___/___/___

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-___ GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **If no, include the dependent's physical address below**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

2 **CHECK ONE:**

☐ **Add**
☐ **Remove**
☐ **Update**

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ___/___/___

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-___ GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **If no, include the dependent's physical address below**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

3 **CHECK ONE:**

☐ **Add**
☐ **Remove**
☐ **Update**

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ___/___/___

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-___ GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **If no, include the dependent's physical address below**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

*"State registered domestic partners" means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030 and who have been issued a certificate of state registered domestic partnership by the secretary.
**Tobacco use is defined as an average of at least four times per week, except for religious or ceremonial purposes.
***These fields are optional. Your response will help us to better serve all communities.

Change Information for My Dependents Continued

Only changes reflected on this form will be updated on your plan. If you are not making any changes, leave this page blank. Adding a dependent outside of Open Enrollment requires a Qualifying Event. Make sure you use full, legal names. For all plans, dependent children must be age 25 or younger as of their effective date. If you have additional family members to be enrolled, please include them on a separate sheet with this change form.

4 CHECK ONE:

☐ **Add**
☐ **Remove**
☐ **Update**

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ___/___/___

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-___ GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **If no, include the dependent's physical address below**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

5 CHECK ONE:

☐ **Add**
☐ **Remove**
☐ **Update**

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ___/___/___

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-___ GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **If no, include the dependent's physical address below**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

6 CHECK ONE:

☐ **Add**
☐ **Remove**
☐ **Update**

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ___/___/___

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-___ GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **If no, include the dependent's physical address below**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

*"State registered domestic partners" means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030 and who have been issued a certificate of state registered domestic partnership by the secretary.
**Tobacco use is defined as an average of at least four times per week, except for religious or ceremonial purposes.
***These fields are optional. Your response will help us to better serve all communities.

Read, Sign & Submit

Certification of Completion and Correctness

I affirm that I am requesting a change in coverage for myself and/or my enrolled family dependents and that the answers given in this change form are complete and correct. I am providing these answers as part of the procedure required by Providence Health Plan to request a change in my insurance coverage. I understand and agree that no change in coverage shall be in force until the effective date determined by Providence Health Plan and that Providence Health Plan may contact me to clarify this request.

As a member, I understand I have the right to inspect the information in my file. I understand that I can visit **ProvidenceHealthPlan.com** to educate myself about Providence Health Plan's privacy practices. I understand that I can get a copy of Providence Health Plan's Notice of Privacy Practices by going to **ProvidenceHealthPlan.com/NOPP** or by calling Customer Service at **503-574-7500** or **800-878-4445 (TTY: 711)** 8 a.m. to 5 p.m. (Pacific Time), Monday through Friday.

Signature

1. I understand that this is an Individual & Family health insurance plan. I verify that neither my employer nor any third party will be paying the premium on this policy except as permitted by state or federal regulation.
2. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
3. I am the parent or legal guardian of all dependent children listed on this change form.
4. I verify that the physical address I provided on this change form for myself is accurate, as well as any other address provided by me for any dependents.
5. I understand that I must update my information with Providence Health Plan if anything changes.
6. I verify that any newly enrolled dependent(s) are not entitled to Medicare Part A and/or enrolled in Medicare Part B. (The federal government does not allow health plans to issue an Individual & Family health insurance plan that duplicates coverage available through Medicare.)
7. Providence Columbia plans DO NOT include pediatric dental coverage. I affirm that I will obtain pediatric dental coverage through a separate Marketplace-certified pediatric dental plan, and that I will notify Providence Health Plan if I do not obtain coverage. I understand that if I do not obtain pediatric dental coverage, Providence Health Plan will discontinue my or any of my enrolled dependents health benefits until reasonable assurance is obtained.

By signing, I agree to the above conditions. Policyholder signature and date required.

Signature is considered valid only if it is handwritten ("wet") or e-signed.
A copy of legal guardianship or power of attorney must accompany this form if not signed by the Policyholder.

SIGNATURE OF POLICYHOLDER, LEGAL GUARDIAN OR POWER OF ATTORNEY

TODAY'S DATE (MM/DD/YYYY)

PRINT NAME

☐ Signed by Policyholder for Spouse or Domestic Partner

SIGNATURE OF SPOUSE OR DOMESTIC PARTNER (IF APPLICABLE)

Submission Options

Return completed form electronically:
Log in to your myProvidence account and send us a secure message with a copy of your completed change form attached.

Mail completed form to:
Providence Health Plan
P.O. Box 4649
Portland, OR 97208-4649

Fax completed form to:
503-574-8131

Race/Ethnicity Questionnaire

Providence Health Plan

The following questions are optional. Your responses will help us to better serve all communities.

Which of the following describes your racial or ethnic identity? Please check all that apply.

Hispanic and Latino/a/x

- ☐ Hispanic or Latino/a/x Central American
- ☐ Hispanic or Latino/a/x Mexican
- ☐ Hispanic or Latino/a/x South American
- ☐ Other Hispanic or Latino/a/x

Native Hawaiian or Pacific Islander

- ☐ Guamanian or Chamorro
- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander

Other

- ☐ Other
- ☐ I don't know.
- ☐ I don't want to answer.

American Indian or Alaska Native

- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

White

- ☐ Caucasian/White (no national affiliation)
- ☐ Eastern European/Slavic
- ☐ Western European
- ☐ Other White (African, Australian, New Zealand descent)

Middle Eastern or North African

- ☐ Middle Eastern
- ☐ North African

Black or African American

- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Afro-Latinx/Bi-racial/Other
- ☐ Other Black

Asian

- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

If you checked more than one category above, is there one you think of as your primary racial or ethnic identity?

- ☐ **Yes** (please specify): _____
- ☐ **No:** I do not have just one primary racial or ethnic identity.
- ☐ **No:** I identify as Biracial or Multiracial.
- ☐ **N/A:** I only checked one category above.
- ☐ **N/A:** I don't know.
- ☐ **N/A:** I don't want to answer.

What is your preferred spoken language?

- ☐ English
- ☐ Spanish
- ☐ Chinese - Other
- ☐ Mandarin
- ☐ Cantonese
- ☐ Vietnamese
- ☐ Russian
- ☐ German
- ☐ French
- ☐ Tagalog
- ☐ Japanese
- ☐ Korean
- ☐ Arabic
- ☐ Decline/Unknown
- ☐ Other

What is your preferred written language?

- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ Simplified Chinese
- ☐ Russian
- ☐ Other
- ☐ **N/A:** I don't know.
- ☐ **N/A:** I don't want to answer.

Providence Health Plan

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, relgion, gender identity, marital status or sex.

Providence Health Plan and Providence Health Assurance:

Provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If need these services, you can call us at **503-574-7500** or **800-878-4445 (TTY: 711)**.

If you believe that Providence Health Plan and Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Ronni Nichuals, Non-discrimination Coordinator
P.O. Box 4158
Portland, OR 97208-4158
Phone: 503-574-6236
Fax: 503-574-8757
Email: Ronni.Nichuals@providence.org

If need help filing a grievance, call us at **503-574-7500** or **800-878-4445 (TTY: 711)** for assistance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, DC 20201

Phone: **800-368-1019** or **800-537-7697**

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Members of Oregon Plans may file a complaint with the Division of Financial Regulation at **888-877-4894** or visit **https://dfr.oregon.gov/Pages/index.aspx**.

Members of Washington Plans may file a complaint with the Washington Office of the Insurance Commissioner electronically through the Office of the Insurance Commissioner Complaint portal available at **https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status**, or by phone at **800-562-6900** or **800-537-7697 (TTY: 711)** or visit **www.insurance.wa.gov**. Complaint forms are available at **http://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx**.

DO NOT RETURN THIS PAGE TO PROVIDENCE HEALTH PLAN

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-878-4445 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-878-4445 (TTY: 711).

Traditional Chinese: 注意：如果您說中文，您可以免費獲得語言支援服務。請致電 1-800-878-4445 (TTY: 711)。

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

Farsi:

توجه: اگر به زبان فارسی صحبت می‌کنید، تسهیلات زبانی به صورت رایگان به شما ارائه می‌شود. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

Japanese: お知らせ: 日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오.

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले निम्न भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छन् । 1-800-878-4445 (TTY: 711) मा फोन गर्नुहोस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-878-4445 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-878-4445 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ អាចមានសេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃពីលោកអ្នក។ សូមហៅទូរស័ព្ទលេខ 1-800-878-4445 (TTY: 711)។

Laotian: ເຊີນຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫຼືອ ດ້ານພາສາ ໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-878-4445 (TTY: 711).

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