Handbook insert that includes changes to Service Authorizations, Actions, Appeals and Complaints

Service Authorizations and Actions

When GuildNet Gold HMO SNP determines that services are covered solely by Medicaid, we will make decisions about your care following these rules:

Prior Authorization

Some covered services require **prior authorization** (approval in advance) from GuildNet before you receive them or in order to be able to continue receiving them. You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

Adult Day Health Care*	Includes medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure activities, dental, pharmaceutical, and other ancillary services. Services furnished in approved SNF or extension site.
Home Health Care Services Not Covered by Medicare* including nursing, home health aide, occupational, physical and speech therapies	Medicaid covered home health services include the provision of skilled services not covered by Medicare (e.g. physical therapist to supervise maintenance program for patients who have reached their maximum restorative potential or nurse to pre-fill syringes for disabled individuals with diabetes) and /or home health aide services as required by an approved plan of care.
Medical and Surgical Supplies*	These items are generally considered to be one-time only use, consumable items routinely paid for under the Durable Medical Equipment category of fee-for–service Medicaid**.**
Medical Social Services*	Assessment, arranging and providing aid for social problems related to maintaining individual at home.
Parental and Enteral Formulas and Nutritional Supplements*	Coverage of enteral formula and nutritional supplements is limited to coverage only for nasogastric, jejunostomy, or gastrostomy tube feeding.
Outpatient Rehabilitation*	Medicaid covered occupational therapy, physical therapy and speech and language therapy is limited to twenty (20) visits per therapy per calendar year except for children under age 21 and the developmentally disabled.
Personal Care* (such as assistance with bathing, eating, dressing, toileting and walking)	Medically necessary assistance with activities such as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks.
Private Duty Nursing*	Private duty nursing services in your home provided by a person possessing a license and current registration from the NYS Education Department to practice as a registered professional nurse or licensed practical nurse.

	Private duty nursing services are covered when determined by the attending physician to be medically necessary. Nursing services may be intermittent, part-time or continuous and provided in accordance with the ordering physician, registered physician assistant or certified nurse practitioner's written treatment plan.
Consumer Directed Personal Assistance Services (CDPAS)*	When you are eligible to self-direct your own care, you or your designated representative will be able to choose your own home attendant that can be employed through a GuildNet provider. This will allow you to hire, supervise, train or terminate your home attendant if necessary. The home attendant will be able to perform personal care task as well as additional services. This is a voluntary program you can enter into or leave at any time.
Nutrition	Assessment of nutritional status/needs, development and evaluation of treatment plans, nutritional education, in-service education, includes cultural considerations.
Home Delivered Meals and/or meals in a group setting such as a day care	Meals provided at home or in congregate settings, e.g., senior centers to individuals unable to prepare meals or have them prepared.
Social Day Care	Structured comprehensive program providing socialization, supervision, monitoring, personal care and nutrition in a protective setting.
Non-Emergency Transportation	Transportation essential for an enrollee to obtain necessary medical care and services under the plan's benefits or Medicaid fee-for-service. Includes ambulette, invalid coach, taxicab, livery, public transportation, or other means appropriate to the enrollee's medical condition and a transportation attendant to accompany the enrollee, if necessary.
Social/Environmental Supports (such as chore services, home modifications or respite)	Services and items to support member's medical need. May include home maintenance tasks, homemaker/chore services, housing improvement, and respite care.
Personal Emergency Response System	Electronic device that enables individuals to secure help in a physical, emotional or environmental emergency.
Nursing Home Care not covered by Medicare	Skilled nursing facility days provided by a licensed facility in excess of the first 100 days in the Medicare Advantage benefit period.
Hearing Aid Batteries	Services include hearing aid replacement parts such as batteries.

When you ask for approval of a treatment or service, it is called a **service authorization request**. To get a service authorization request you or your doctor may call your GuildNet Case

Manager at 1-800-815-0000 (TTY 711) or send your request in writing to 250 W57th St, 10th floor, New York, NY 10107. The services with an * also require a physician's order.

Services will be authorized in a certain amount and for a specific period of time. This is called an **authorization period**.

You will also need to get prior authorization if you are getting one of these services now, but need to get more of the care during an authorization period. This is called **concurrent review**.

What happens after we get your service authorization request

The health plan has a review team to be sure you get the services we promise. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against acceptable medical standards.

We may decide to deny a service authorization request or to approve it for an amount that is less than requested. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor, a nurse or a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

After we get your request, we will review it under a **standard** or **fast track** process. You or your doctor can ask for a fast track review if it is believed that a delay will cause serious harm to your health. If your request for a fast track review is denied, we will tell you and your request will be handled under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or fair hearings you will have if you don't agree with our decision.

Timeframes for prior authorization requests

- Standard review: We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.

- Fast track review: We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Timeframes for concurrent review requests

- Standard review: We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 14 days after we received your request.

- Fast track review: We will make a decision within 1 work day of when we have all the information we need. You will hear from us within 72 hours after we receive your request. We will tell you within 1 work day if we need more information.

If we need more information to make either a standard or fast track decision about your service request, the timeframes above can be extended up to 14 days. We will:

- Write and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-800-815-0000 (TTY 711) or writing.

You or someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

If you are not satisfied with our answer, you have the right to file an appeal with us. See the Appeal section later in this handbook.

If for some reason you do not hear from us on time it is the same as if we denied your service authorization request. If this happens, you have the right to request a State Fair Hearing. See the Fair Hearing section later in this handbook.

Other Decisions About Your Care

Sometimes we will do a concurrent review on the care you are receiving to see if you still need the care. We may also review other treatments and services you have already received. This is called **retrospective review**. We will tell you if we take these other actions.

Timeframes for notice of other actions

- In most cases, if we make a decision to reduce, suspend or stop a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.
- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. **You will not have to pay for any care you received that was covered by the plan or by Medicaid even if we later deny payment to the provider.**

WHAT TO DO IF YOU HAVE A COMPLAINT ABOUT OUR PLAN OR WANT TO APPEAL A DECISION ABOUT YOUR CARE

As a Dually-Eligible member of our plan, the way you make complaints and appeals about your services will depend on whether GuildNet Gold determines that the services are covered by Medicare or Medicaid.

- For complaints and appeals about a service that is covered only by Medicare (e.g. chiropractic services), you will follow the rules outlined in Chapter 9 of GuildNet Gold's Medicare Evidence of Coverage.
- For complaints and appeals about a service that is covered only by Medicaid (e.g. personal care services, private duty nursing, non-emergency transportation, dental services, etc.), you will follow the Medicaid rules listed below.
- For complaints and appeals about all other services covered by GuildNet Gold you may choose to follow either the Medicare rules outlined in Chapter 9 of the GuildNet Gold Evidence of Coverage or the Medicaid rules described below. If you choose to follow the Medicare rules, you cannot use your Medicaid complaint and appeal rights, including the right to a state Fair Hearing regarding the complaint or appeal. But if you choose to follow the Medicaid rules, you will have up to 60 days from the day of GuildNet Gold's notice of denial of coverage to use your Medicare complaint and appeal rights.

GuildNet Gold will explain the complaints and appeals processes available to you depending on the complaint you have. Call member services at 1-800-815-0000 (TTY 711) to get more information on your rights and the options available to you.

MEDICAID RULES FOR APPEALS AND COMPLAINTS

Plan Appeals

There are some treatments and services that you need to get approval before you receive them or in order to be able to continue receiving them. This is called **prior authorization.** Asking for approval of a treatment or service is called a **service authorization request.** This process is described earlier in this handbook. The notice of our decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **Initial Adverse Determination.**

If you are not satisfied with our decisions about your Medicaid care, there are steps you can take.

Your provider can ask for reconsideration:

If we made a decision about your service authorization request without talking to your doctor, your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one workday.

You can file an Plan Appeal:

- If you are not satisfied with our decision about your service authorization request, you have **60 days** after hearing from us to file an Plan appeal.
- You can do this yourself or ask someone you trust to file the Plan appeal for you. You can call Member Services 1-800-815-0000 (TTY 711) if you need help filing a Plan appeal.
- We will not treat you any differently or act badly toward you because you file a Plan appeal.
- The Plan appeal can be made by phone or in writing. If you make an appeal by phone, unless it is fast tracked, you must also send your Plan appeal to us in writing.

Your Plan Appeal will be reviewed under the fast track process:

- If you or your doctor asks to have your Plan appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied, we will tell you and your appeal will be reviewed under the standard process; **or**
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided.
- Fast track Plan appeals can be made by phone and do not have to be followed up in writing.

Aid to Continue while appealing a decision about your care

If we decide to reduce, suspend or stop services you are getting now, you may be able to continue receiving the services while you wait for your appeal to be decided. You must ask for an appeal:

- Within ten days from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur.

If your appeal results in another denial, you may have to pay for the cost of any continued benefits that you received.

If we deny your appeal and you are not satisfied, you can appeal further using the External Appeals process or Fair Hearing process described below.

What happens after we get your Plan Appeal

- Within 15 days, we will send you a letter to let you know we are work on your Plan appeal. We will let you know if we need additional information to make our decision.

- We will send you a case file free of charge which includes copy of the medical records and any other information and records we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.
- Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- You can also provide information to be used in making the decision in person or in writing. Call Plan at 1-800-815-0000 (TTY 711) if you are not sure what information to give us.
- You will be given the reasons for our decision and our clinical rationale, if it applies. The notice of the Plan Appeal decision to deny your request or to approve it for an amount that is less than requested is called a **Final Adverse Determination.**
- **If you think our Final Adverse Determination is wrong:**
  - You can ask for a Fair Hearing. See Fair Hearing section of this handbook
  - For some decisions, you may be able to ask for an External Appeal. See the External Appeal section of this handbook.
  - You or someone you trust can file a complaint with the New York State Department of Health at 1-866-712-7197,

Timeframes for Plan Appeals

- **Standard appeals:** If we have all the information we need, we will tell you our decision in **30 days** from when you asked for your Plan Appeal. A written notice of our decision will be sent within 2 work days from when we make the decision.

- **Fast track appeals**: If we have all the information we need, fast track Plan Appeal decisions will be made in 2 work days from your Plan Appeal but not more than 72 hours from when you asked for your Plan Appeal.
  - We will tell you within 72 hours if we need more information.
  - We will tell you our decision by phone and send a written notice later.

If we do not have the information we need to make either a standard or fast track decision about your Plan Appeal within the above timeframes we will:

- Write to tell you that we need more time to collect the information. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest;
- Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-800-815-0000 (TTY 711) or writing.

You or someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review your action appeal. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling

1-866-712-7197.

If you do not receive a response to your Plan Appeal or we do not decide in time, including extensions, you can ask for a Fair Hearing. See Fair Hearing section of this handbook.

If we do not decide your Plan Appeal on time, and we said the service was not medically necessary, was experimental or investigational, not different from care you can get in the plan's network, or available from a participating provider who has correct training and experience to meet your needs, the original denial will be reversed. This means your service authorization request will be approved.

External Appeals

If the plan decides to deny coverage for a medical service you and your doctor asked for because it is not medically necessary or because it is experimental or investigational, not different from care you can get in the plan's network, or available from a participating provider who has correct training and experience to meet your needs, you can ask New York State for an independent **external appeal**. This is called an External Appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment. You do not have to pay for an external appeal.

Before you appeal to the state:

1. You must file an Plan Appeal with the plan and get the plan's Final Adverse Determination; **or**
2. If you have not gotten the service, and you ask for a fast track Plan Appeal, you may ask for an expedited External Appeal at the same time. Your doctor will have to say an expedited Appeal is necessary; **or**
3. You and the plan may agree to skip the plan's appeals process and go directly to External Appeal; **or**
4. You can prove the plan did not follow the rules correctly when processing your Plan Appeal.

You have **4 months** after you receive the plan's Final Adverse Determination to ask for an External Appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement.

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services. You can call Member Services at 1-800-815-0000 (TTY 711) if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' website at www.dfs.ny.gov .
- Contact the health plan at 1-800-815-0000 (TTY 711)

Your External Appeal will be decided in 30 days. More time (up to five work days) may be needed if the External Appeal reviewer asks for more information. You and the plan will be told the final decision within two days after the decision is made.

You can get a faster decision if your doctor says that a delay will cause serious harm to your health. This is called an **expedited External Appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less. The reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

If you ask for a Plan Appeal, and you receive a Final Adverse Determination that denies, reduces, suspends or stops your service, you can ask for a Fair Hearing, and External Appeal or both. If you ask for both a Fair Hearing and an External Appeal, the decision of the fair hearing officer will be the one that counts.

Fair Hearings

You must first ask for a Plan Appeal and receive a Final Adverse Determination. You will then have 120 calendar days from the date of the Final Adverse Determination to ask for a Fair Hearing.

You may ask for a Fair Hearing from New York State if:

- You are not happy with a decision your local department of social services or the State Department of Health made about your staying or leaving the Medicaid Advantage Plus Program.

- You are not happy with a decision that your doctor would not order one of the services listed above that you wanted. You feel that the doctor's decision stops or limits your Medicaid benefits. You must file a complaint and an appeal with GuildNet Gold. If GuildNet Gold agrees with your doctor, you may ask for a State Fair Hearing.

- You asked for a Plan Appeal, and the time for us to decide your Plan Appeal has expired, including any extensions. If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing.

- You are not happy with a decision that we made about your care. You feel the decision limits your Medicaid benefits. You are not happy we decided to:
    - reduce, suspend or stop care you were getting; or
    - deny care you wanted; or
    - deny payment for care you received

If you asked for a Plan Appeal, and receive a Final Adverse Determination that reduces, suspends, or stops care you are getting now, you can continue to get the services your doctor ordered while you wait for your Fair Hearing to be decided. You must ask for a Fair Hearing within 10 days from the date of the Final Adverse Determination or by the time the action takes effect, whichever is later. However, if you choose to ask for services to be continued, and lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for a decision.

The decision you receive from the Fair Hearing will be final.

If you filed a complaint or appeal under Medicare rules, you may not then request a state Fair Hearing about the same complaint or appeal.

You can use one of the following ways to request a Fair Hearing:

- By phone. Call toll free 1-800-342-3334
- By fax at 518-473-6735
- By Internet at www.otda.state.ny.us/oah/forms.asp
- By mail:

  NYS Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Hearing Unit
  P.O. Box 122023
  Albany, New York 12201-2023

When you ask for a Fair Hearing about a decision GuildNet Gold made, we must send you a copy of the **evidence packet.** This information we used to make our decision about your care. The plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before the hearing, you can call 1-800-815-0000 (TTY 711) to ask for it

Remember, you can file a complaint anytime to the New York State Department of Health by calling 1-866-712-7197. Call Member Services at 1-800-815-0000 (TTY 711) if you have any questions

Complaints

We hope our plan serves you well. If you have a problem with the care or treatment you receive from our staff or providers or you do not like the quality of care or services you receive from us, call Member Services at 1-800-815-0000 (TTY 711) or write to Member Services. Please remember that complaints about services that are only a benefit under Medicare should be handled through the GuildNet Gold Medicare complaint process. Complaints about services only covered by Medicaid should be handled through the GuildNet Gold Medicaid complaint process. You can choose to use either the Medicare or Medicaid complaints process for complaints about services that GuildNet Gold determines are a benefit under both Medicare and Medicaid.

Most problems can be solved right away. Problems that are not solved over the phone and any complaint that comes in about a Medicaid service will be handled according to the procedures described below. You can ask someone you trust to file the complaint for you. If you need our help because of a hearing or vision impairment, or if you need translation services, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

How to File a Complaint with the Plan:

To file by phone, call Member Services at 1-800-815-0000 (TTY 711) between 8am and 8pm, Monday through Sunday. If you call us after hours, leave a message. We will call you back the next work day. If we need more information to make a decision, we will tell you.

You can write us with your complaint or call the Member Services number and request a complaint form. It should be mailed to 250 W57th Street, 10th Floor, New York, NY 10107.

What happens next:

If we don't solve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 work days. The letter will tell you:

- who is working on your complaint
- how to contact this person
- if we need more information

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters it will be reviewed by one or more qualified health care professionals.

After we review your complaint:

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.
- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint but you will hear from us in no more than 7 days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in 3 work days.
- You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need.
- If we are unable to make a decision about your Complaint because we don't have enough information, we will send a letter and let you know.

Complaint Appeals

If you disagree with a decision we made about your complaint, you or someone you trust can file a **complaint appeal** with the plan.

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have at least 60 work days after hearing from us to file a complaint appeal;
- You can do this yourself or ask someone you trust to file the complaint appeal for you;

- The complaint appeal must be made in writing. If you make an appeal by phone it must be followed up in writing. After your call, we will send you a form which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal:

After we get your complaint appeal we will send you a letter within 15 work days. The letter will tell you:

- who is working on your complaint appeal
- how to contact this person
- if we need more information

Your complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about your complaint. If your complaint appeal involves clinical matters, your case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, that were not involved in making the first decision about your complaint.

We will let you know our decision within 30 work days from the time we have all information needed. If a delay would risk your health, you will get our decision in 2 work days of when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-866 712-7197.

GuildNet Gold HMO SNP and GuildNet Gold Plus FIDA Plan MMP POS comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. GuildNet does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

GuildNet:

- Provides 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)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact GuildNet at 1-800-815-0000, TTY 711, Monday through Sunday, 8am to 8pm.

If you believe that GuildNet Gold or GuildNet Gold Plus FIDA Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with. Joel Levi, Chief Compliance Officer, 250 West 64th Street, New York, NY 10023, 212-769-6212, fax 212-595-4907, LeviJ@Lighthouseguild.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Joel Levi is available to help you.

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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-815-0000 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-815-0000（TTY：711）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-815-0000 (телетайп: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-815-0000 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-815-0000 (TTY: 711)번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-815-0000 (TTY: 711).

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט (TTY: 711) 1-800-815-0000-1.

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-800-815-0000 (TTY: 711)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-815-0000 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-815-0000 (رقم هاتف الصم والبكم: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-815-0000 (ATS : 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں .(TTY: 711) 1-800-815-0000

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-815-0000 (TTY: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-815-0000 (TTY: 711).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-815-0000 (TTY: 711).