



Health Net 2017 Individual Enrollment Form

Please contact Health Net if you need information in another language or format.

To enroll in Health Net, please provide the following information:

Please check which plan you want to enroll in:

Health Net Healthy Heart (HMO)

(includes prescription drug coverage)

- Alameda, Stanislaus \$157 per month
- Fresno \$0 per month
- Los Angeles, Orange \$20 per month
- Placer, Sacramento \$167 per month
- Riverside, San Bernardino \$30 per month
- San Diego \$0 per month
- San Francisco \$127 per month
- Yolo \$99 per month

Health Net Gold Select (HMO)

(includes prescription drug coverage)

- Los Angeles, Orange \$0 per month
- Riverside, San Bernardino \$0 per month

Health Net Seniority Plus Green (HMO)

(does not include prescription drug coverage)

- Alameda, Placer, Sacramento, Sonoma, Stanislaus \$139 per month
- Los Angeles, Riverside, San Bernardino \$0 per month

Health Net Seniority Plus Ruby (HMO)

(includes prescription drug coverage)

- Kern \$0 per month
- Santa Clara \$220 per month

Health Net Ruby Select (HMO)

(includes prescription drug coverage)

- Alameda \$69 per month
- Fresno \$0 per month
- San Francisco \$29 per month
- Yolo \$0 per month

Health Net Seniority Plus Sapphire (HMO)

(includes prescription drug coverage)

- Los Angeles, Orange, San Diego \$36.20* per month
- Kern \$36.20* per month
- Riverside, San Bernardino \$36.20* per month

Health Net Seniority Plus Sapphire Premier (HMO) (includes prescription drug coverage)

- Fresno, Los Angeles, Orange, San Diego, San Francisco \$36.20* per month
- Riverside, San Bernardino \$36.20* per month

Health Net Jade (HMO SNP)¹

(Cardiovascular Disorders, Chronic Heart Failure (CHF), Diabetes) (includes prescription drug coverage)

- Kern, Los Angeles, Orange \$0 per month

¹You must meet specific enrollment criteria to enroll in this plan.

Health Net Seniority Plus Amber I (HMO SNP)¹
(All Dual Eligible beneficiaries enrolled in Medicare and Medi-Cal) (includes prescription drug coverage)

Kern, Los Angeles, Orange, Riverside,
San Bernardino \$36.20* per month

Health Net Seniority Plus Amber II Premier (HMO SNP)¹
(Full Dual Eligible beneficiaries enrolled in Medicare and Medi-Cal) (includes prescription drug coverage)

Fresno \$36.20* per month

Health Net Seniority Plus Amber II (HMO SNP)¹
(Full Dual Eligible beneficiaries enrolled in Medicare and Medi-Cal) (includes prescription drug coverage)

Fresno, Los Angeles, Orange,
San Diego, San Francisco \$36.20* per month
 Kern, Tulare \$36.20* per month
 Riverside, San Bernardino \$36.20* per month

*Actual premium based on Low Income Subsidy status.

¹You must meet specific enrollment criteria to enroll in this plan.

Please check one box below if you would like to enroll in Optional Supplemental Benefits for an additional monthly premium:

- Optional Supplemental Buy-Up #1: \$25 per month
- Optional Supplemental Buy-Up #2: \$35 per month
- Optional Supplemental Buy-Up #6: \$30 per month
- Optional Supplemental Buy-Up #7: \$12 per month
- Optional Supplemental Buy-Up #8: \$23 per month
- Optional Supplemental Buy-Up #9: \$20 per month

Monthly Plan Premium Amount (including optional supplemental package premium amount)

\$ _____ Requested Effective Date: ____/____/_____

White – Health Net

Yellow – Member

Last name First name Middle initial Mr. Mrs. Ms.

Birth date Sex: M F Home phone number - -

Permanent residence street address (PO Box is not allowed) - -

City County State ZIP code

Mailing address (only if different from your permanent residence address)
 Street address

City State ZIP code

Emergency contact **Phone number** - -

Relationship to you **Email address**

Please provide your Medicare insurance information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card
- OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE  **HEALTH INSURANCE**

SAMPLE ONLY

Name: _____

Medicare Claim Number _____ **Sex** _____

Is Entitled To **Effective Date**

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

White – Health Net

Yellow – Member

Paying your plan premium

For Medicare Advantage Prescription Drug plans with no premiums: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or “Electronic Funds Transfer (EFT)” each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Health Net the Part D-IRMAA.

For all plans with premiums: You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or “Electronic Funds Transfer (EFT)” each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Health Net the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

- Get a bill
- Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name

Bank routing number

Bank account number

Account type: Checking Saving

White – Health Net

Yellow – Member

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? Yes No

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you had a successful kidney transplant or you don't need dialysis; otherwise, we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Health Net? Yes No

If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage

ID # for this coverage

Group # for this coverage

3. Are you a resident in a long-term care facility, such as a nursing home? Yes No

If "Yes," please provide the following information:

Name of institution

Phone number of institution

Address of institution (number and street)

4. Are you enrolled in your State Medicaid program? Yes No

If "Yes," please provide your Medicaid number:

5. Do you or your spouse work? Yes No

6. Do you have Cardiovascular Disorders, Chronic Heart Failure (CHF) and/or Diabetes? Yes No

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

White – Health Net

Yellow – Member

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format:

Spanish Chinese

Large print

Please contact Health Net at 1-800-977-6738 if you need information in another format or language than what is listed above. From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, our office hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. On weekends and certain holidays, your call will be handled by our automated phone system. TTY users should call 711.



Please read this important information

If you currently have health coverage from an employer or union, joining Health Net could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Health Net. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read and sign below

By completing this enrollment application, I agree to the following:

Health Net is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. For plans without prescription drugs, I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15–December 7 of every year), or under certain special circumstances.

Health Net serves a specific service area. If I move out of the area that Health Net serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Health Net, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Net when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

White – Health Net

Yellow – Member

I understand that beginning on the date Health Net coverage begins, I must get all of my health care from Health Net, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Health Net and other services contained in my Health Net *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH NET WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Health Net, he/she may be paid based on my enrollment in Health Net.

Release of Information: By joining this Medicare health plan, I acknowledge that Health Net will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Net will release my information including my prescription drug event data (if applicable) to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature

Today's date

<input type="text"/>							
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M M D D Y Y Y Y

If you are the authorized representative, you must sign above and provide the following information:

Name

Address

Phone number

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>
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Relationship to enrollee

White – Health Net

Yellow – Member

OFFICE USE ONLY:

Name of staff member/agent/broker (if assisted in enrollment):

Plan ID #:

Effective date of coverage:
M M D D Y Y Y Y

ICEP/IEP AEP SEP (type): Not eligible

Health Net sales representative / Authorized agent

(Individual sales representative/agent who completed the application)

Agent type (select one): Authorized agent Health Net employee

Complete section or place printed label here:

Sales rep / Agent name: Health Net ID #:

Sales rep / Agent NPN #:

Agency / FMO affiliation: Health Net ID #:
(if applicable)

This information must match your approved Health Net licensing records.

Agency phone #: - -

Email:

Agency FMO phone # (if applicable): - -

Sales representative/Authorized agent application receipt date:
M M D D Y Y Y Y

(Applications must be received at Health Net within 1 calendar day of this date)

Application receipt location: Appointment Sales event Walk-in

Other (specify):

Provider information for HMO plans:

PCP name: PCP ID:

PPG name: PPG ID:

Is PCP/PPG selected accepted for the plan chosen? Yes No

Current patient? Yes No

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Yellow – Member

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- I recently moved outside of the service area for my current plan, or I recently moved and this plan is a new option for me. I moved on (insert date).

M	M	D	D	Y	Y	Y	Y
- I recently was released from incarceration. I was released on (insert date).

M	M	D	D	Y	Y	Y	Y
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date).

M	M	D	D	Y	Y	Y	Y
- I recently obtained lawful presence status in the United States. I got this status on (insert date).

M	M	D	D	Y	Y	Y	Y
- I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date).

M	M	D	D	Y	Y	Y	Y
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date).

M	M	D	D	Y	Y	Y	Y
- I recently left a PACE program on (insert date).

M	M	D	D	Y	Y	Y	Y
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date).

M	M	D	D	Y	Y	Y	Y
- I am leaving employer or union coverage on (insert date).

M	M	D	D	Y	Y	Y	Y
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a Special Needs Plan (SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date).

M	M	D	D	Y	Y	Y	Y

If none of these statements applies to you or you're not sure, please contact Health Net at 1-800-977-6738 (TTY users should call 711) to see if you are eligible to enroll. From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, our office hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. On weekends and certain holidays, your call will be handled by our automated phone system.

White – Health Net

Yellow – Member

Health Net complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at: (HMO) 1-800-275-4737, (HMO SNP) 1-800-431-9007 (TTY: 711), 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.

If you believe that Health Net 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 by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center 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, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

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

Health Net of California, Inc. and Health Net Community Solutions, Inc. have a contract with Medicare and the State of CA to offer HMO SNP coordinated care plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.

You must continue to pay your Medicare Part B premium. However, for full-dual beneficiaries, the State will cover your Part B premium as long as you retain your Medicaid eligibility.

This information is available for free in other languages. Please call our Member Service number at: (HMO) 1-800-275-4737, (HMO SNP) 1-800-431-9007. From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, our office hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. On weekends and certain holidays, your call will be handled by our automated phone system. TTY users should call 711.

Esta información está disponible en forma gratuita en otros idiomas. Llame al número de nuestro Departamento de Servicios al Afiliado en California: (HMO) 1-800-275-4737, (HMO SNP) 1-800-431-9007. Desde el 1 de octubre hasta el 14 de febrero, nuestro horario de atención es de 8:00 a.m. a 8:00 p.m., los 7 días de la semana, excepto ciertos días feriados. Sin embargo, después del 14 de febrero, nuestro horario de atención será de 8:00 a.m. a 8:00 p.m., de lunes a viernes. Los fines de semana y ciertos días feriados su llamada será atendida por nuestro sistema automático de teléfono. Los usuarios de TTY deben llamar al 711.

本資訊備有其他語言版本，可免費提供。請致電我們 California：(HMO) 1-800-275-4737，(HMO SNP) 1-800-431-9007。從 10 月 1 日到 2 月 14 日期間，我們每週 7 天，每天上午 8:00 到下午 8:00 間提供服務 (不含特定假日)。但於 2 月 14 日開始，我們的服務時間改為週一到週五，上午 8:00 至下午 08:00。週末及 特定假日，您的來電時會轉接到 本公司自動語音 系統。聽障專線使用者請撥 711。

FRM008663ED00 (7/16)

White – Health Net

Yellow – Member

Multi-Language Insert

Multi-language Interpreter Services

English:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Spanish:

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Chinese:

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 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)。

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

French:

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (ATS :711).

Vietnamese:

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Korean:

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711) 번으로 전화해 주십시오.

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Russian:

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (телетайп: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (رقم هاتف الصم والبكم: 711).

Hindi:

ध्यान दें: यदि आप हदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711) पर कॉल करें।

Italian:

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Portuguese:

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

French Creole:

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Polish:

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Japanese:

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)まで、お電話にてご連絡ください。

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
با بگیرید. 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)

Armenian:

ՈՒՇԱՂԱՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Ջանգահարեք 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY (հեռատիպ)՝ 711):

Cambodian:

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អូល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ
1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)។

Punjabi:

ਪਿਆਰ ਦਾ ਦਿ1 ਤਾਂ ਭਾਸ਼ਾ ਵੀਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। ,ਜੇ ਤੁਸੀ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ :
1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)ਤੇ ਕਾਲ ' ਕਰੋ।

Thai:

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Laotian:

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Serbo-Croatian:

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Ukrainian:

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (телетайп: 711).

