Proof of qualifying life event form

Who should use this form?

- A qualifying life event is a change in your life that lets you apply for health care coverage outside the annual open enrollment period. This is called a special enrollment period. Examples include getting married, moving to a Kaiser Permanente service area with access to new health plans, or losing coverage because you lost your job.
- Use this Proof of Qualifying Life Event Form to submit your proof when applying directly to Kaiser Permanente if you or a dependent had a qualifying life event. You may also use this form to submit your proof when applying to your state's health benefit exchange in Colorado or Washington (except Clark, Cowlitz, and certain other counties*). For all other exchange applications, check your state's exchange for information on how to submit proof for exchange plans. It can help you figure out which type of proof you'll need to provide for your qualifying life event.
  - **Kaiser Permanente for Individuals and Families (KPIF) plan members** should submit their proof along with the Account Change Form.
  - **People who aren't Kaiser Permanente for Individuals and Families (KPIF) plan members** should submit their proof along with their Application for health coverage.

Who should not use this form?

- If you or any dependent you're applying for are entitled to Medicare Part A or are enrolled in Medicare Part B, that applicant is not eligible to apply for new KPIF coverage. Visit **kp.org/medicare** to learn more about your Medicare plan options or to apply for Medicare coverage.

How to use this form

California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington*

- Fill out Steps 1, 2, and 3.
- Submit this form and proof of your qualifying life event with your application or Account Change Form (if applicable). See "Submitting your proof" on page 16 for details.

When to submit your proof

California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington*

You have a limited period of time to submit your proof. Visit **kp.org/specialenrollment** for details and deadlines.

If we don't get your proof in time, we'll have to cancel your application or account change request. You may apply again if your special enrollment period is still in effect.

For applications submitted on **buykp.org**, submit your proof online.

Need help?

Visit **kp.org/specialenrollment** for more information. You can also call us at **1-800-494-5314** (TTY **711**), or contact your broker/producer or Kaiser Permanente representative.

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

986406374 National 2023

Primary applicant name

STEP 1: Primary applicant information

Who is the primary applicant?

- In an individual plan, the primary applicant is the person who'll be covered by the health plan.
- In a family plan, the primary applicant is the family member on the health plan who's authorized to make changes to the account.
- In a child-only plan (where offered) for a child under 18, the child is the primary applicant.

Please note: This isn't an application for health care coverage. To get health care coverage, you need to submit an application or Account Change Form.

First name

MI

Date of birth (mm/dd/yyyy)

Last name

Phone (mobile phone if available)

Application ID number (if you applied online)

Social Security number (if any)

Medical record number (if any)

Home address (no P.O. boxes)

City

State

ZIP code

Parent/legal guardian (if primary applicant is under 18)

First name

Last name

Broker/producer or Kaiser Permanente representative (if any)

First name

Last name

Primary applicant name

STEP 2: Qualifying life event information

Qualifying life event number from Step 3

Date of qualifying event (mm/dd/yyyy)

For loss of minimum essential health coverage, the date of the qualifying event is the last full day you were covered under your prior plan.

STEP 3: Proof of your qualifying life event

- Check one box for your qualifying life event and one box for the proof you're sending (unless otherwise noted). Make sure the qualifying event and the type of proof apply to your state.
- Send one type of proof, unless otherwise noted.
- Send copies of official documents, not originals.
- Write this information about the primary applicant on the first page of your proof or on an attached page:
  - First and last name
  - Health/medical record number (if any)
  - Home address (no P.O. boxes)
  - Date of birth

Qualifying life event	Type of proof
☐ **1. Loss of minimum essential health coverage** California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington*	**From your employer** ☐ Letter or other document from your employer stating the employer dropped or will drop coverage or benefits for you, your spouse, or dependent family member and the date this coverage ended or will end. ☐ Letter or document from your employer stating the employer stopped or will stop contributing to the cost of coverage and the date this contribution ended or will end. ☐ Letter showing your employer's offer of COBRA coverage, including the effective date, or stating when your COBRA coverage ended or will end. ☐ Pay stubs of current and previous hours if you lost coverage because of a reduction in work hours. ☐ Proof of age and evidence of loss of coverage when a dependent child turns 26 and is no longer eligible to be covered under a parent's health plan. **From your carrier or Medicaid, Medi-Cal, Medicare, or other government programs** ☐ Letter from your carrier showing a coverage end date, including a COBRA coverage end date. ☐ Letter from your student health plan indicating when student health coverage ended or will end. ☐ Letter or notice from Medicaid, Medi-Cal, or the Children's Health Insurance Program (CHIP) stating when Medicaid, Medi-Cal, or CHIP coverage ended or will end. ☐ Letter or notice from a government program, like TRICARE, Peace Corps, AmeriCorps, or Medicare, stating when that coverage ended or will end. **Other** ☐ Dated military discharge papers or Certificate of Release, including the date coverage ended or will end, if you're losing coverage because you're no longer on active military duty. ☐ Dated and signed written verification from a broker/producer or Kaiser Permanente representative, or dated letter from the carrier, if you are or were enrolled in a non-calendar-year plan that's ending, including the date the plan ended.

Important: This is NOT a qualifying life event if:

- You're losing coverage because you didn't pay your premiums.
- Your plan was rescinded.
- You had Medicare Part B coverage and don't have any other coverage.
- You voluntarily ended your coverage.
- You had temporary or short-term coverage like traveler's insurance.

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
Loss of minimum essential health coverage *(continued)* Colorado Important: This is NOT a qualifying life event if: • You're losing coverage because you didn't pay your premiums. • Your plan was rescinded. • You had Medicare Part B coverage and don't have any other coverage. • You voluntarily ended your coverage.	No proof required with your application.
2. Gaining, becoming, or losing a dependent, or death of a subscriber or a dependent	
☐ **2a. Gaining or becoming a dependent through marriage** **Check 2 boxes total.** District of Columbia, Virginia This event requires proof of prior coverage. Visit **kp.org/specialenrollment** for more information.	**Provide one of these:** Proof of minimum essential coverage for one spouse for at least one full day in the last 60 days from your prior carrier (applicants within the U.S. only): ☐ Paid premium invoice proving coverage within the last 60 days. ☐ Employer benefit record proving coverage within the last 60 days. **And provide one of these:** ☐ Marriage certificate/license showing the date of the marriage. ☐ Official government record of the marriage, including a foreign record of marriage showing the date of the marriage.

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **2b. Gaining or becoming a dependent through marriage or domestic partnership registration** **Check 2 boxes total.** California, Georgia, Hawaii, Maryland, Oregon, Washington* This event requires proof of prior coverage. Visit **kp.org/specialenrollment** for more information.	**Provide one of these:** Proof of minimum essential coverage for one spouse for at least one full day in the last 60 days from your prior carrier (applicants within the U.S. only): ☐ Paid premium invoice proving coverage within the last 60 days. ☐ Employer benefit record proving coverage within the last 60 days. **And provide:** ☐ Marriage certificate/license showing the date of the marriage. ☐ Official government record of the marriage, including a foreign record of marriage showing the date of the marriage. ☐ Official government record, including date of domestic partnership registration.
☐ **2c. Gaining or becoming a dependent through marriage or civil union partnership** **Check 2 boxes total.** Colorado† This event requires proof of prior coverage. Visit **kp.org/specialenrollment** for more information.	**Provide one of these:** Proof of minimum essential coverage for one spouse for at least one full day in the last 60 days from your prior carrier (applicants within the U.S. only): ☐ Paid premium invoice proving coverage within the last 60 days. ☐ Employer benefit record proving coverage within the last 60 days. **If you can't provide proof of minimum essential coverage, you may send in one of the following:** ☐ Official documentation showing that you are an American Indian or Native Alaskan. ☐ Proof that you lived for one or more days during the 60 days before your life event or during your most recent open enrollment period in a service area where no qualified health plan was available through your state's health benefit exchange. You can provide a screenshot from the exchange website or other proof from the exchange. ☐ Proof that you lived outside of the United States or in a United States territory for one or more days during the 60 days before the date of the qualifying life event. **And provide one of these:** ☐ Marriage certificate/license/other documentation showing the date of the marriage. ☐ Official government record, including date of civil union.

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

†In Colorado, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **2d. Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care** California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington*	**Birth of a child** ☐ Birth certificate or application for a birth certificate for the child. ☐ Record from a clinic, hospital, doctor, midwife, institution, or other provider stating the child's date of birth. ☐ Military record showing the child's birth date and place of birth. ☐ Official government record of a foreign birth certificate showing the child's birth date and place of birth. ☐ Religious record showing the child's birth date and place of birth. ☐ Letter or other document from the carrier, like an Explanation of Benefits, showing that services related to birth or after-birth care were given to the child, the mother, or both, including the dates of service. **Adoption or foster care** ☐ Adoption letter or record showing date of adoption, dated and signed by a court official. ☐ Court order showing when the order started. It must have a filing date stamp. ☐ Official government record of a domestic adoption, or placement for adoption or foster care, showing the child's birth date and place of birth. ☐ U.S. Department of Homeland Security immigration document for foreign adoptions, including the date of the adoptions. ☐ Medical support court order. It must have a court filing date stamp. ☐ Foster care papers dated and signed by a court official.
Colorado†	**Birth of a child** ☐ Birth certificate or application for a birth certificate for the child. **Adoption or foster care** ☐ Adoption letter or record showing date of adoption, dated and signed by a court official. ☐ Court order showing when the order started. It must have a court filing date stamp. ☐ Official government record of a domestic adoption, or placement for adoption or foster care, showing the child's birth date and place of birth. ☐ U.S. Department of Homeland Security immigration document for foreign adoptions, including the date of the adoptions. ☐ Medical support court order. It must have a court filing date stamp. ☐ Foster care papers dated and signed by a court official.

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

†In Colorado, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **2e. Losing a dependent through divorce, dissolution of domestic partnership, or legal separation** California, Maryland	☐ Divorce decree, dissolution agreement, or separation agreement with court filing date stamp.
☐ **2f. Losing a dependent through divorce, dissolution of a civil union partnership, or legal separation** Colorado†	☐ Divorce decree, dissolution agreement, or separation agreement with court filing date stamp.
☐ **2g. Death of the subscriber or a dependent** California, Maryland	☐ Death certificate.
Colorado†	☐ Death certificate or obituary.
☐ **3. Child support order or other court order to cover a dependent** California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington*	☐ Signed court order with court filing date stamp.
Colorado†	☐ Signed court order with court filing date stamp or dated Designated Beneficiary Agreement.

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

†In Colorado, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **4. Permanent relocation with access to new plans** California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington* Choose **Permanent relocation with access to new plans**, if one of the following applies to you: • You moved from a non–Kaiser Permanente area to a Kaiser Permanente area. • You moved to a new state. • You moved from a foreign country or a United States territory. • You moved from a county that did not offer a qualified health plan. This event requires proof of prior coverage. Visit **kp.org/specialenrollment** for more information.	**Provide one of these:** Proof of minimum essential coverage for all applicants from your prior carrier for at least one full day in the last 60 days (applicants moving within the U.S. only). ☐ Paid premium invoice proving coverage within the last 60 days. ☐ Employer benefit record proving coverage within the last 60 days. **And, within 60 days of your move, provide any of these – one with your prior residential address and one with your new residential address (no P.O. boxes):** ☐ Lease or rental agreement. ☐ Insurance documents, like homeowner's, renter's, or life insurance policy or statement. ☐ Mortgage deed, if it states the owner uses the property as the primary residence. ☐ Mortgage or rental payment receipt. ☐ Mail from the Department of Motor Vehicles, like a valid driver's license, vehicle registration, or change of address card. ☐ Mail from a government agency to your address, like a Social Security statement, or a notice from Temporary Assistance for Needy Families or Supplemental Nutrition Assistance Program. ☐ Your valid state ID. ☐ Internet, cable, or other utility bill (including any public utility like a gas or water bill) or other confirmation of service (including a utility hookup or work order). ☐ Telephone bill showing your address (cellphone or wireless bills are OK). ☐ Mail from a financial institution, like a bank statement. ☐ U.S. Postal Service change of address confirmation letter. ☐ Pay stub showing your address. ☐ Voter registration card showing your name and address. ☐ Documents from the Department of Corrections, jail, or prison showing recent release or parole, including a dated order of parole, dated order of release, or an address certification. ☐ Naturalization papers signed and dated within the last 60 days or green card, Education Certificate, or visa (if you moved to the U.S. from another country).

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
Permanent relocation with access to new plans *(continued)* Colorado Choose **Permanent relocation with access to new plans**, if one of the following applies to you: • You moved from a non–Kaiser Permanente area to a Kaiser Permanente area. • You moved to a new residence within our Kaiser Permanente service area where your current health plan is not available or you have additional health plan options. • You moved to a new state. • You moved from a foreign country or a United States territory. • You moved from a county that did not offer a qualified health plan.	No proof required with your application.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **5. Changes in employer health coverage making you eligible for a premium tax credit** California, Georgia, Hawaii, Oregon, Colorado†, District of Columbia, Maryland, Virginia, Washington* You must apply through your state's health benefit exchange **You're now eligible for a premium tax credit because your coverage through your employer has changed.**	☐ Letter from employer stating change in minimum essential health coverage and showing determination date. ☐ Letter or other document from your employer stating the employer changed or will change coverage or benefits for you or for your spouse or dependent family member, so it's no longer considered qualifying health coverage, and the date this coverage or benefits changed or will change.
☐ **6. Determination by your state's health benefit exchange of exceptional circumstances** California, Colorado†, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington*	☐ Letter or notice from your state's health benefit exchange stating you're eligible for a special enrollment period and showing determination date.
☐ **7. Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)** California, Colorado†, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington*	☐ Letter or other documentation stating you are now eligible to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA) including the date showing when you are first eligible for the ICHRA or QSEHRA.

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

†In Colorado, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **8. Domestic violence or spousal abandonment occurring within the household** California, Colorado†, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington*	☐ Attestation stating you're a victim of domestic abuse or spousal abandonment.
☐ **9. Discontinuation of employer contribution to COBRA premium** California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington*	☐ Proof from your employer or COBRA administrator showing subsidies had been provided and the date they will end.
Colorado	No proof required with your application.
☐ **10. Release from incarceration** California, Colorado†	☐ Documents from the Department of Corrections, jail, or prison showing recent release or parole, including a dated order of parole, dated order of release, or an address certification.
☐ **11. Misinformation about your enrollment in minimum essential coverage** California	☐ Notice from your state's health benefit exchange or the Department of Managed Health Care stating you're eligible for a special enrollment period and showing determination date.
☐ **12. Provider network changes** California	☐ Notice that the provider is no longer participating in the health benefit plan and showing determination date.
☐ **13. Contract violation** California	☐ Written confirmation, with date, from the Department of Managed Health Care that the health plan in which you're enrolled has substantially violated a material provision of your contract.
Colorado	No proof required with your application.

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

†In Colorado, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **14. Eligibility for app-based transportation or delivery network company health care stipend** California	☐ A copy or a screen shot of your quarterly hours driven.
☐ **15. Determination by the Department of Insurance Commissioner of exceptional circumstances** Colorado†	☐ Letter or notice from the Department of Insurance Commissioner stating you're eligible for a special enrollment period and showing determination date.
☐ **16. Loss of Short Term Health Coverage** Colorado	No proof required with your application.
☐ **17. Initial confirmation of pregnancy by a health care practitioner** District of Columbia, Maryland	☐ A document from your health care practitioner dated within the last 90 days confirming your initial pregnancy.
☐ **18. Change in employer health coverage making you ineligible for a premium tax credit or change in eligibility for cost share reductions** Maryland	☐ Letter from employer stating change in minimum essential health coverage and showing determination date. ☐ Letter or other document from your employer stating the employer changed or will change coverage or benefits for you or for your spouse or dependent family member, so it's no longer considered qualifying health coverage, and the date this coverage or benefits changed or will change.
☐ **19. Tax Season Easy Enrollment** Maryland You must apply through your state's health benefit exchange	Your financial information has been validated by the Comptroller, and you don't need to send additional proof.

†In Colorado, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **20. Easy Enrollment for Unemployment Insurance Claimants** Maryland You must apply through your state's health benefit exchange	If you received a letter from Maryland Health Connection stating you preliminarily qualified for health care coverage. Your financial information has been validated by the Maryland Health Connection and you don't need to send additional proof.
☐ **21. Change in immigration status** California, Colorado†, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington* You must apply through your state's health benefit exchange	☐ Official documentation of a change in citizenship or immigration status.
☐ **22. Coverage as American Indian/Native Alaskan** California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington* You must apply through your state's health benefit exchange	☐ Official documentation showing your status.
Colorado	No proof required with your application.

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

†In Colorado, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **23. Change in income changing your eligibility for federal financial assistance** California, Colorado†, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington* You must apply through your state's health benefit exchange.	**Provide one of these:** Proof of minimum essential coverage for all applicants from your prior carrier for at least one full day in the last 60 days. ☐ Paid premium invoice proving coverage within the last 60 days. ☐ Employer benefit record proving coverage within the last 60 days. **And provide:** ☐ Most recent eligibility determination from your state's health benefit exchange showing determination date.
☐ **24. Tax Time Enrollment** Colorado	Your financial information has been validated through your tax filing and Connect for Health Colorado and you don't need to send additional proof.
☐ **25. Paid penalty for not having health coverage** California You must apply through your state's health benefit exchange	If you paid the Individual Shared Responsibility Penalty to California's Franchise Tax Board within the last 60 days, no proof is required.
☐ **26. Loss of pregnancy related coverage** Maryland	☐ Letter or notice from Medicaid or Children's Health Insurance Program (CHIP) stating when Medicaid or CHIP coverage ended or will end.
☐ **27. Loss of medically needy coverage** Maryland	☐ Letter or notice from Medicaid or Children's Health Insurance Program (CHIP) stating when Medicaid or CHIP coverage ended or will end.

*In Washington, go to **kp.org/specialenrollment** to see if Kaiser Permanente is collecting proof for exchange qualifying life events in your county.

†In Colorado, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **28. Enrollment in any non-calendar year group health plan, individual health insurance coverage, or qualified small employer health reimbursement arrangement (QSEHRA)** Maryland	☐ Dated and signed written verification from an agent/broker/producer or dated letter from the carrier, if you are or were enrolled in a non-calendar year plan that's ending, including the date the plan ended.
☐ **29. Demonstrating that a qualified plan substantially violated a material provision of its contract in relation to the enrollee** Maryland	☐ Written confirmation, with date, from the Maryland Insurance Administration that the health plan in which you're enrolled has substantially violated a material provision of your contract.
☐ **30. Being potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and being determined ineligible after open enrollment has ended or more than 60 days after the qualifying event** Maryland	☐ Letter or notice from Medicaid or Children's Health Insurance Program (CHIP), with date, stating that you are ineligible for coverage.

Submitting your proof

How are you applying?

- **If you're applying online:** Sign in at **kp.org/apply** and upload your proof. You don't need to upload this form.
- **In Washington (except Clark, Cowlitz, and certain other counties):**
  - If you're applying online through Washington Healthplanfinder: Sign in to **kp.org/wa/if-exchange** and upload your proof. You don't need to upload this form with your proof.
  - If you're applying online directly through Kaiser Permanente: Sign in to **kp.org/wa/if-myaccount** and upload this form with your proof.
- **If you're applying by mail or fax:** Use the information on this page to send your proof and this form to the address or fax number below.
- **If you're applying through the health benefit exchange:** The health benefit exchange may require submission of proof.

Send application or Account Change Form and proof along with this form:

By mail

Kaiser Permanente for Individuals and Families
P.O. Box 23127
San Diego, CA 92193-9921

By fax

1-855-355-5334

To download an Account Change Form, visit kp.org/specialenrollment.

By submitting a signed application or Account Change Form and proof of your qualifying life event, you're saying that the qualifying life event happened. It's important that we get proof of your qualifying life event. We will rely on your signature and proof to decide if you can enroll during a special enrollment period. If we determine that the qualifying life event didn't happen, or we learn of any other inaccuracy in the information that is included in the application, Account Change Form or any other information that you submit, we may take legal action. The legal action may include but is not limited to canceling your coverage retroactively to the day it started. You may also be responsible for the full charges of any services that you received.

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Nondiscrimination Notice

Discrimination is against the law. Kaiser Permanente follows State and Federal civil rights laws.

Kaiser Permanente does not unlawfully discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call our Member Service Contact Center at **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week (except closed holidays). If you cannot hear or speak well, please call **711**.

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, or another format, call our Member Service Contact Center and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with Kaiser Permanente if you believe we have failed to provide these services or unlawfully discriminated in another way. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You may also speak with a Member Services representative about the options that apply to you. Please call Member Services if you need help filing a grievance.

You may submit a discrimination grievance in the following ways:

- **By phone:** Call Member Services at **1 800-464-4000** (TTY **711**) 24 hours a day, 7 days a week (except closed holidays)
- **By mail:** Call us at **1 800-464-4000** (TTY **711**) and ask to have a form sent to you
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at kp.org/facilities for addresses)
- **Online:** Use the online form on our website at kp.org

You may also contact the Kaiser Permanente Civil Rights Coordinators directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office of Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office of Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**
- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office of Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or 1**-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:

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

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

- **Online:** Visit the Office of Civil Rights Complaint Portal at:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Aviso de no discriminación

La discriminación es ilegal. Kaiser Permanente cumple con las leyes de los derechos civiles federales y estatales.

Kaiser Permanente no discrimina ilícitamente, excluye ni trata a ninguna persona de forma distinta por motivos de edad, raza, identificación de grupo étnico, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, género, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, condición médica, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

Kaiser Permanente ofrece los siguientes servicios:

- Ayuda y servicios sin costo a personas con discapacidades para que puedan comunicarse mejor con nosotros, como lo siguiente:
  - ♦ intérpretes calificados de lenguaje de señas,
  - ♦ información escrita en otros formatos (braille, impresión en letra grande, audio, formatos electrónicos accesibles y otros formatos).
- Servicios de idiomas sin costo a las personas cuya lengua materna no es el inglés, como:
  - ♦ intérpretes calificados,
  - ♦ información escrita en otros idiomas.

Si necesita nuestros servicios, llame a nuestra Central de Llamadas de Servicio a los Miembros al **1-800-464-4000** (TTY **711**) las 24 horas del día, los 7 días de la semana (excepto los días festivos). Si tiene deficiencias auditivas o del habla, llame al **711**.

Este documento estará disponible en braille, letra grande, casete de audio o en formato electrónico a solicitud. Para obtener una copia en uno de estos formatos alternativos o en otro formato, llame a nuestra Central de Llamadas de Servicio a los Miembros y solicite el formato que necesita.

Cómo presentar una queja ante Kaiser Permanente

Usted puede presentar una queja por discriminación ante Kaiser Permanente si siente que no le hemos ofrecido estos servicios o lo hemos discriminado ilícitamente de otra forma. Consulte su *Evidencia de Cobertura (Evidence of Coverage)* o *Certificado de Seguro (Certificate of Insurance)* para obtener más información. También puede hablar con un representante de Servicio a los Miembros sobre las opciones que se apliquen a su caso. Llame a Servicio a los Miembros si necesita ayuda para presentar una queja.

Puede presentar una queja por discriminación de las siguientes maneras:

- **Por teléfono:** llame a Servicio a los Miembros al **1 800-464-4000** (TTY **711**), las 24 horas del día, los 7 días de la semana (excepto los días festivos)**.**

- **Por correo postal:** llámenos al **1 800-464-4000** (TTY **711**) y pida que se le envíe un formulario**.**
- **En persona:** llene un formulario de Queja o reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte su directorio de proveedores en kp.org/facilities [cambie el idioma a español] para obtener las direcciones).
- **En línea:** utilice el formulario en línea en nuestro sitio web en kp.org/espanol.

También puede comunicarse directamente con el coordinador de derechos civiles (Civil Rights Coordinator) de Kaiser Permanente a la siguiente dirección:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

Cómo presentar una queja ante la Oficina de Derechos Civiles del Departamento de Servicios de Atención Médica de California *(Solo para beneficiarios de Medi-Cal)*

También puede presentar una queja sobre derechos civiles ante la Oficina de Derechos Civiles (Office of Civil Rights) del Departamento de Servicios de Atención Médica de California (California Department of Health Care Services) por escrito, por teléfono o por correo electrónico:

- **Por teléfono:** llame a la Oficina de Derechos Civiles del Departamento de Servicios de Atención Médica (Department of Health Care Services, DHCS) al **916-440-7370** (TTY **711**).
- **Por correo postal:** llene un formulario de queja o envíe una carta a:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Los formularios de queja están disponibles en:
  http://www.dhcs.ca.gov/Pages/Language_Access.aspx (en inglés).
- **En línea:** envíe un correo electrónico a CivilRights@dhcs.ca.gov**.**

Cómo presentar una queja ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU.

Puede presentar una queja por discriminación ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU. (U.S. Department of Health and Human Services). Puede presentar su queja por escrito, por teléfono o en línea:

- **Por teléfono:** llame al **1-800-368-1019** (TTY **711** o al 1**-800-537-7697**).
- **Por correo postal:** llene un formulario de queja o envíe una carta a:

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

Los formularios de quejas están disponibles en
http://www.hhs.gov/ocr/office/file/index.html (en inglés).

- **En línea:** visite el Portal de quejas de la Oficina de Derechos Civiles en: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** (en inglés).

反歧視聲明

歧視是違反法律的行為。Kaiser Permanente遵守州政府與聯邦政府的民權法。

Kaiser Permanente不因年齡、人種、族群認同、膚色、原國籍、文化背景、祖籍、宗教、生理性別、社會性別、性認同、性表現、性取向、婚姻狀況、身體或精神殘障、病況、付款來源、遺傳資訊、公民身份、母語或移民身份而非法歧視、排斥或差別對待任何人。

Kaiser Permanente提供下列服務：

- 為殘障人士提供免費協助與服務以幫助其更好地與我們溝通，例如：
  - ♦ 合格手語翻譯員
  - ♦ 其他格式的書面資訊（盲文版、大字版、語音版、通用電子格式及其他格式）
- 為母語非英語的人士提供免費語言服務，例如：
  - ♦ 合格口譯員
  - ♦ 其他語言的書面資訊

如果您需要上述服務，請打電話**1-800-464-4000** (TTY **711**) 給會員服務聯絡中心，每週7天，每天24小時（節假日除外）。如果您有聽力或語言困難，請打電話**711**。

若您提出要求，我們可為您提供本文件的盲文版、大字版、錄音卡帶或電子格式。如要得到上述一種替代格式或其他格式的版本，請打電話給會員服務聯絡中心並索取您需要的格式。

如何向Kaiser Permanente投訴

如果您認為我們未能提供上述服務或有其他形式的非法歧視行為，您可向Kaiser Permanente提出歧視投訴。請參閱您的《承保範圍說明書》*(Evidence of Coverage)* 或《保險證明》*(Certificate of Insurance)* 瞭解詳情。您也可以向會員服務部代表諮詢適用於您的選項。如果您在投訴時需要協助，請打電話給會員服務部。

您可透過下列方式投訴歧視：

- **電話**：打電話**1 800-464-4000** (TTY **711**) 聯絡會員服務部，每週7天，每天24小時（節假日除外）
- **郵寄**：打電話**1 800-464-4000** (TTY **711**) 與我們聯絡，要求將投訴表寄給您
- **親自提出**：在保險計劃下屬設施的會員服務辦公室填寫投訴或索賠／申請表（請在kp.org/facilities網站的保健業者名錄上查詢地址）
- **線上**：使用kp.org網站上的線上表格

您也可直接與Kaiser Permanente民權事務協調員聯絡，地址如下：

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

如何向加州保健服務部民權辦公室投訴（僅限*Medi-Cal*受益人）

您也可透過書面方式、電話或電子郵件向加州保健服務部民權辦公室提出民權投訴：

- **電話**：打電話**916-440-7370** (TTY **711**) 聯絡保健服務部 (DHCS) 民權辦公室
- **郵寄**：填寫投訴表或寄信至：

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  您可在網站上**http://www.dhcs.ca.gov/Pages/Language_Access.aspx**取得投訴表
- **線上**：發送電子郵件至CivilRights@dhcs.ca.gov

如何向美國健康與民眾服務部民權辦公室投訴

您可向美國健康與民眾服務部民權辦公室提出歧視投訴。您可透過書面、電話或線上提出投訴：

- **電話**：打電話**1-800-368-1019**（TTY **711**或1-**800-537-7697**）
- **郵寄**：填寫投訴表或寄信至：

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

  您可在網站上取得投訴表：
  http:www.hhs.gov/ocr/office/file/index.html取得投訴表
- **線上**：訪問民權辦公室投訴入口網站：
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf。

Thông Báo Không Phân Biệt Đối Xử

Phân biệt đối xử là trái với pháp luật. Kaiser Permanente tuân thủ các luật dân quyền của Tiểu Bang và Liên Bang.

Kaiser Permanente không phân biệt đối xử trái pháp luật, loại trừ hay đối xử khác biệt với người nào đó vì lý do tuổi tác, chủng tộc, nhận dạng nhóm sắc tộc, màu da, nguồn gốc quốc gia, nền tảng văn hóa, tổ tiên, tôn giáo, giới tính, nhận dạng giới tính, cách thể hiện giới tính, khuynh hướng giới tính, tình trạng hôn nhân, tình trạng khuyết tật về thể chất hoặc tinh thần, bệnh trạng, nguồn thanh toán, thông tin di truyền, quyền công dân, ngôn ngữ mẹ đẻ hoặc tình trạng nhập cư.

Kaiser Permanente cung cấp các dịch vụ sau:

- Phương tiện hỗ trợ và dịch vụ miễn phí cho người khuyết tật để giúp họ giao tiếp hiệu quả hơn với chúng tôi, chẳng hạn như:
  - ♦ Thông dịch viên ngôn ngữ ký hiệu đủ trình độ
  - ♦ Thông tin bằng văn bản theo các định dạng khác (chữ nổi braille, bản in khổ chữ lớn, âm thanh, định dạng điện tử dễ truy cập và các định dạng khác)
- Dịch vụ ngôn ngữ miễn phí cho những người có ngôn ngữ chính không phải là tiếng Anh, chẳng hạn như:
  - ♦ Thông dịch viên đủ trình độ
  - ♦ Thông tin được trình bày bằng các ngôn ngữ khác

Nếu quý vị cần những dịch vụ này, xin gọi đến Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi theo số **1-800-464-4000** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần (đóng cửa ngày lễ). Nếu quý vị không thể nói hay nghe rõ, vui lòng gọi **711** .

Theo yêu cầu, tài liệu này có thể được cung cấp cho quý vị dưới dạng chữ nổi braille, bản in khổ chữ lớn, băng thu âm hay dạng điện tử. Để lấy một bản sao theo một trong những định dạng thay thế này hay định dạng khác, xin gọi đến Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi và yêu cầu định dạng mà quý vị cần.

Cách đệ trình phàn nàn với Kaiser Permanente

Quý vị có thể đệ trình phàn nàn về phân biệt đối xử với Kaiser Permanente nếu quý vị tin rằng chúng tôi đã không cung cấp những dịch vụ này hay phân biệt đối xử trái pháp luật theo cách khác. Vui lòng tham khảo *Chứng Từ Bảo Hiểm (Evidence of Coverage)* hay *Chứng Nhận Bảo Hiểm (Certificate of Insurance)* của quý vị để biết thêm chi tiết. Quý vị cũng có thể nói chuyện với nhân viên ban Dịch Vụ Hội Viên về những lựa chọn áp dụng cho quý vị. Vui lòng gọi đến ban Dịch Vụ Hội Viên nếu quý vị cần được trợ giúp để đệ trình phàn nàn.

Quý vị có thể đệ trình phàn nàn về phân biệt đối xử bằng các cách sau đây:

- **Qua điện thoại:** Gọi đến ban Dịch Vụ Hội Viên theo số **1-800-464-4000** (TTY **711**) 24 giờ trong ngày, 7 ngày trong tuần (đóng cửa ngày lễ)
- **Qua thư tín:** Gọi chúng tôi theo số **1-800-464-4000** (TTY **711**) và yêu cầu gửi mẫu đơn cho quý vị

- **Trực tiếp:** Hoàn tất mẫu đơn Than Phiền hay Yêu Cầu Thanh Toán/Yêu Cầu Quyền Lợi tại văn phòng dịch vụ hội viên ở một Cơ Sở Thuộc Chương Trình (truy cập danh mục nhà cung cấp của quý vị tại kp.org/facilities để biết địa chỉ)
- **Trực tuyến:** Sử dụng mẫu đơn trực tuyến trên trang mạng của chúng tôi tại kp.org

Quý vị cũng có thể liên hệ trực tiếp với Điều Phối Viên Dân Quyền của Kaiser Permanente theo địa chỉ dưới đây:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

Cách đệ trình phàn nàn với Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế California *(Dành Riêng Cho Người Thụ Hưởng Medi-Cal)*

Quý vị cũng có thể đệ trình than phiền về dân quyền với Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế California bằng văn bản, qua điện thoại hay qua email:

- **Qua điện thoại:** Gọi đến Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế (Department of Health Care Services, DHCS) theo số **916-440-7370** (TTY **711**)
- **Qua thư tín:** Điền mẫu đơn than phiền và hay gửi thư đến:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Mẫu đơn than phiền hiện có tại: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**
- **Trực tuyến:** Gửi email đến CivilRights@dhcs.ca.gov

Cách đệ trình phàn nàn với Văn Phòng Dân Quyền của Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ.

Quý vị cũng có quyền đệ trình than phiền về phân biệt đối xử với Văn Phòng Dân Quyền của Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ. Quý vị có thể đệ trình than phiền bằng văn bản, qua điện thoại hoặc trực tuyến:

- **Qua điện thoại:** Gọi **1-800-368-1019** (TTY **711** hay **1-800-537-7697**)
- **Qua thư tín:** Điền mẫu đơn than phiền và hay gửi thư đến:

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

  Mẫu đơn than phiền hiện có tại
  http:www.hhs.gov/ocr/office/file/index.html

- **Trực tuyến:** Truy cập Cổng Thông Tin Than Phiền của Văn Phòng Dân Quyền tại: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.**

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, materials translated into your language, or in alternative formats. You can also request auxiliary aids and devices at our facilities. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

Arabic: خدمات الترجمة الفورية متوفرة لك مجانًا على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. يمكنك أيضاً طلب مساعدات إضافية وأجهزة في مرافقنا. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لمستخدمي خدمة الهاتف النصي يرجي الاتصال على الرقم (**711**).

Armenian: Ձեզ կարող է անվճար օգնություն տրամադրվել լեզվի հարցում՝ օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Դուք նաև կարող եք խնդրել օժանդակ օգնություններ և սարքեր մեր հաստատություններում: Պարզապես զանգահարեք մեզ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ, շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգտվողները պետք է զանգահարեն **711**:

Chinese: 您每週 7 天，每天 24 小時均可獲得免費語言協助。您可以申請口譯服務、要求將資料翻譯成您所用語言或轉換為其他格式。您還可以在我們的場所內申請使用輔助工具和設備。我們每週 7 天，每天 24 小時均歡迎您打電話 **1-800-757-7585** 前來聯絡（節假日休息）。聽障及語障專線 (TTY) 使用者請撥 **711**。

Farsi: خدمات زبانی در 24 ساعت شبانروز و 7 روز هفته بدون اخذ هزینه در اختیار شما است. شما می توانید برای خدمات مترجم شفاهی، ترجمه مدارک به زبان شما و یا به صورتهای دیگر درخواست کنید. شما همچنین می توانید کمکهای جانبی و وسایل .کمکی برای محل اقامت خود درخواست کنید کافیست در 24 ساعت شبانروز و 7 روز هفته (به استثنای روزهای تعطیل) با ما به شماره **1-800-464-4000** تماس بگیرید. کاربران ناشنوا (TTY) با شماره **711** تماس بگیرند.

Hindi: बिना किसी लागत के दुभाषिया सेवाएँ, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप एक दुभाषिये की सेवाओं के लिए, बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों के लिए अनुरोध कर सकते हैं। आप हमारे सुविधा-स्थलों में सहायक साधनों और उपकरणों के लिए भी अनुरोध कर सकते हैं। बस केवल हमें **1-800-464-4000** पर, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें। TTY उपयोगकर्ता **711** पर कॉल करें।

Hmong: Muaj kec pab txhais lus pub dawb rau koj, 24 teev ib hnub twg, 7 hnub ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom. Koj kuj thov tau lwm yam kev pab thiab khoom siv hauv peb tej tsev hauj lwm. Tsuas hu rau **1-800-464-4000**, 24 teev ib hnub twg, 7 hnub ib lim tiam twg (cov hnub caiv kaw). Cov neeg siv TTY hu **711**.

Japanese: 当院では、言語支援を無料で、年中無休、終日ご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは資料を別の書式でも依頼できます。補助サービスや当施設の機器についてもご相談いただけます。お気軽に **1-800-464-4000** までお電話ください（祭日を除き年中無休）。TTY ユーザーは **711** にお電話ください。

Khmer: ជំនួយភាសា គឺឥតគិតថ្លៃថ្លៃដល់អ្នកឡើយ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែឯកសារដែលបានបកប្រែទៅជាភាសាខ្មែរ ឬជាទំរង់ជំនួសផ្សេងៗទៀត។ អ្នកក៏អាចស្នើសុំឧបករណ៍និងបរិក្ខារជំនួយទំនាក់ទំនងសម្រាប់អ្នកពិការនៅទីតាំងរបស់យើងផងដែរ។ គ្រាន់តែទូរស័ព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ 711។

Korean: 요일 및 시간에 관계없이 언어지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스,귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 또한 저희 시설에서 보조기구 및 기기를 요청하실 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000** 번으로 전화하십시오 (공휴일휴무). TTY 사용자번호 **711**.

Laotian: ການຊ່ວຍເຫຼືອດ້ານພາສາມີໃຫ້ໂດຍບໍ່ເສັງຄ່າ ແກ່ທ່ານ, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ. ທ່ານ ສາມາດຮ້ອງຂໍຮັບບໍລິການນາຍພາສາ, ໃຫ້ແປເອກະ ສານເປັນພາສາຂອງທ່ານ, ຫຼື ໃນຮູບແບບອື່ນ. ທ່ານສາມາດຂໍອຸປະກອນຊ່ວຍເສີມ ແລະ ອຸປະກອນ ຕ່າງໆໃນສະຖານບໍລິການຂອງພວກເຮົາໄດ້.ພຽງແຕ່ໂທ ຫາພວກເຮົາທີ່ **1-800-464-4000**, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ (ປິດວັນພັກຕ່າງໆ). ຜູ້ໃຊ້ສາຍ TTY ໂທ **711**.

Mien: Mbenc nzoih liouh wang-henh tengx nzie faan waac bun muangx maiv zuqc cuotv zinh nyaanh meih, yietc hnoi mbenc maaih 24 norm ziangh hoc, yietc norm liv baaiz mbenc maaih 7 hnoi. Meih se haih tov heuc tengx lorx faan waac mienh tengx faan waac bun muangx, dorh nyungc horngh jaa-sic mingh faan benx meih nyei waac, a'fai liouh ginv longc benx haaix hoc sou-guv daan yaac duqv. Meih corc haih tov longc benx wuotc ginc jaa-dorngx tengx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Kungx douc waac mingh lorx taux yie mbuo yiem njiec naaiv **1-800-464-4000**, yietc hnoi mbenc maaih 24 norm ziangh hoc, yietc norm liv baaiz mbenc maaih 7 hnoi. (hnoi-gec se guon gorn zangc oc). TTY nyei mienh nor douc waac lorx **711**.

Navajo: Doo bik'é asíníłáágóó saad bee ata' hane' bee áká e'elyeed nich'į' ąą'át'é, t'áá áłahjį' jíigo dóó tł'ée'go áádóó tsosts'íjí ąą'át'é. Ata' hane' yídíikił, naaltsoos t'áá Diné bizaad bee bik'i' ashchíigo, éí doodago hane' bee didíits'íiłígíí yídíikił. Hane' bee bik'i' di'díítíiłígíí dóó bee hane' didíits'íiłígíí bína'ídiłkidgo yídíikił. Kojį hodiilnih **1-800-464-4000**, t'áá áłahjį', jíigo dóó tł'ée'go áádóó tsosts'íjí ąą'át'é. (Dahodílzingóne' doo nida'anish dago éí da'deelkaal). TTY chodayooł'ínígíí kojį dahalne' **711**.

Punjabi: ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ, ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲਈ, ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸੁਵਿਧਾਵਾਂ ਵਿੱਚ ਵੀ ਸਹਾਇਕ ਸਾਧਨਾਂ ਅਤੇ ਉਪਕਰਣਾਂ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹਾਂ। ਬਸ ਸਿਰਫ਼ ਸਾਨੂੰ **1-800-464-4000** ਤੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਫ਼ੋਨ ਕਰੋ। TTY ਦਾ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ **711** 'ਤੇ ਫ਼ੋਨ ਕਰਨ।

Russian: Мы бесплатно обеспечиваем Вас услугами перевода 24 часа в сутки, 7 дней в неделю. Вы можете воспользоваться помощью устного переводчика, запросить перевод материалов на свой язык или запросить их в одном из альтернативных форматов. Мы также можем помочь вам с вспомогательными средствами и альтернативными форматами. Просто позвоните нам по телефону **1-800-464-4000**, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру **711**.

Spanish: Tenemos disponible asistencia en su idioma sin ningún costo para usted 24 horas al día, 7 días a la semana. Puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o en formatos alternativos. También puede solicitar recursos para discapacidades en nuestros centros de atención. Solo llame al **1-800-788-0616**, 24 horas al día, 7 días a la semana (excepto los días festivos). Los usuarios de TTY, deben llamar al **711**.

Tagalog: May magagamit na tulong sa wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo. Maaari kang humingi ng mga serbisyo ng tagasalin sa wika, mga babasahin na isinalin sa iyong wika o sa mga alternatibong format. Maaari ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. Tawagan lamang kami sa **1-800-464-4000**, 24 na oras bawat araw, 7 araw bawat linggo (sarado sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa **711**.

Thai: มีบริการช่วยเหลือด้านภาษาฟรีตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์ คุณสามารถ ขอใช้บริการล่าม แปลเอกสารเป็นภาษาของคุณ หรือในรูปแบบอื่นได้ คุณสามารถขออุปกรณ์และเครื่องมือช่วยเหลือได้ที่ศูนย์บริการให้ความช่วยเหลือของเรา โดยโทรหา เราที่ **1-800-464-4000** ตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์ (ยกเว้นวันหยุดราชการ) ผู้ใช้ TTY ให้โทร **711**

Ukrainian: Послуги перекладача надаються безкоштовно, цілодобово, 7 днів на тиждень. Ви можете зробити запит на послуги усного перекладача, отримання матеріалів у перекладі мовою, якою володієте, або в альтернативних форматах. Також ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Просто зателефонуйте нам за номером **1-800-464-4000**. Ми працюємо цілодобово, 7 днів на тиждень (крім святкових днів). Номер для користувачів телетайпа: **711**.

Vietnamese: Dịch vụ thông dịch được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, tài liệu phiên dịch ra ngôn ngữ của quý vị hoặc tài liệu bằng nhiều hình thức khác. Quý vị cũng có thể yêu cầu các phương tiện trợ giúp và thiết bị bổ trợ tại các cơ sở của chúng tôi. Quý vị chỉ cần gọi cho chúng tôi tại số **1-800-464-4000**, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi **711**.