



Home- and Community-Based Services Elderly Waiver Information Packet

The Medicaid Home- and Community-Based Services Elderly Waiver (HCBS Elderly) provides service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective.

If you need assistance, please contact Iowa Medicaid Member Services at **1-800-338-8366** or locally in the Des Moines area at **515-256-4606**, Monday through Friday, from 8 a.m. until 5 p.m.

*For telephone accessibility assistance if you are deaf, hard-of-hearing, deaf-blind, or have difficulty speaking, call Relay Iowa TTY at **1-800-735-2942**.*

General Parameters

- ◆ Elderly waiver services are individualized to meet the needs of each member. The following services are available:
 - Adult Day Care
 - Assistive Devices
 - Case Management
 - Chore
 - Consumer-Directed Attendant Care (CDAC)
 - Emergency Response System
 - Home Delivered Meals
 - Home Health Aide
 - Homemaker
 - Mental Health Outreach
 - Nursing Care
 - Nutritional Counseling
 - Respite
 - Senior Companions
 - Transportation
 - Consumer Choices Option
- ◆ All HCBS waiver services must be provided in integrated community-based settings.
- ◆ The services, which are considered necessary and appropriate for the member, will be determined through an interdisciplinary team (IDT) consisting of the member, case manager, Managed Care Organization (MCO) community-based case manager (CBCM), service providers, and other persons the member chooses.
- ◆ An interdisciplinary team (IDT) meets to plan the interventions and supports the member needs to safely maintain the member's physical and mental health in the member's home. The team shall consist of the member, case manager, service providers, and any other persons that the member chooses to include.
- ◆ Each member will have an individualized comprehensive plan (ICP) collaboratively developed with the IDT. This plan documents the agreed upon goals, objectives, and service activities. Also collaboratively developed with the IDT, is an individual crisis plan that is designed to enable the member to prevent, self-manage, alleviate or end a crisis.
- ◆ Members shall access all other services for which they are eligible and that are appropriate to meet their needs as a precondition of eligibility for the elderly waiver.
- ◆ A comprehensive service plan must be developed and reviewed annually with the interdisciplinary team and signed by the case manager or MCO CBCM.
- ◆ The member must choose HCBS services as an alternative to institutional services.
- ◆ In order to receive elderly waiver services, an approved elderly waiver service provider must be available to provide those services.
- ◆ Medicaid waiver services cannot be simultaneously reimbursed with another Medicaid waiver service or a Medicaid service.

- ◆ Elderly waiver services cannot be provided when a person is an inpatient in a medical institution.
- ◆ Members must need and use one billable unit of elderly waiver service during each calendar quarter.
- ◆ The total costs of elderly waiver services cannot exceed the following:
 - Nursing level of care \$1,365.78 per month
 - Skilled level of care \$2,792.65 per month
- ◆ The following is the hierarchy for accessing waiver services:
 1. Private insurance
 2. Medicare
 3. Medicaid
 4. Elderly waiver services
 5. In-Home Health-Related Care (IHHRC)
- ◆ In addition to services available through the elderly waiver assistance may be available through the IHHRC program and or the Rent Subsidy program through the Iowa Finance Authority.

Member Eligibility Criteria

Members may be eligible for HCBS elderly waiver services by meeting the following criteria:

- ◆ Be an Iowa resident and a United States citizen or a person of foreign birth with legal entry into the United States.
- ◆ Be 65 years of age or older.
- ◆ Be determined eligible for Medicaid (Title XIX) *as if* the member was in a medical institution. Members may be Medicaid-eligible before accessing waiver services or be determined eligible through the application process for the waiver program. Additional opportunities to access Medicaid may be available through the waiver program even if the member has previously been determined ineligible.
- ◆ Be determined by the Iowa Medicaid Enterprise, Medical Services Unit, to need nursing **or** skilled level of care.

Service Descriptions

Please note:
HCBS elderly waiver services are individualized to meet the needs of each member. However, decisions regarding what services are appropriate, the number of units or the dollar amounts of the appropriate services is based on the member’s needs as determined by the member and an interdisciplinary team.

Adult Day Care

What: Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care setting.

Where: An adult day care program in the community certified to provide elderly waiver services.

Unit: A unit is hourly **or** a half day (1 to 4 hours) **or** a full day (4 to 8 hours) **or** an extended day (8 to 12 hours).

Assistive Devices

What: Assistive devices are practical equipment products to assist members with activities of daily living and instrumental activities of daily living, which allow the member more independence. These assistive devices may include, but are not limited to:

- ◆ Long reach brush
- ◆ Extra long shoehorn
- ◆ Non-slip grippers to pick up and reach items
- ◆ Dressing aids
- ◆ Shampoo rinse tray
- ◆ Inflatable shampoo tray
- ◆ Double handled cup
- ◆ Sipper lid

Where: In the member's home

Unit: A unit is the cost of one item.

Maximum units: The cost of any one assistive device cannot exceed \$115.62 per unit.

Case Management Services

What: The goal of case management is to enhance the member's ability to exercise choices, make decisions, and take risks that are typical of life, and fully participate in the community.

Case management activities include the following:

- ◆ A comprehensive diagnosis and evaluation
- ◆ Assistance in obtaining appropriate services and living arrangements
- ◆ Coordination of service delivery
- ◆ Ongoing monitoring of the appropriateness of services and living arrangements
- ◆ Crisis assistance to facilitate referral to the appropriate providers

Where: In the member's home and community

Unit: A unit is 15 minutes. Members enrolled with an MCO will receive MCO CBCM instead of case management.

Chore Services

- What:** Chore services are limited to the following services:
- ◆ Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows
 - ◆ Minor repairs to walls, floors, stairs, railings, and handles
 - ◆ Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal
 - ◆ Lawn mowing and removal of snow and ice from sidewalks and driveways
- Does not include:** The following are not included:
- ◆ Leaf raking
 - ◆ Bush and tree trimming
 - ◆ Trash burning
 - ◆ Stick and tree removal
- Where:** In and on the outside of the home and on the member's property
- Unit:** A unit is 15 minutes.

Consumer-Directed Attendant Care (CDAC)

What: Assistance to the member with self-care tasks, which the member would typically do independently if the member was otherwise able. An individual or agency, depending on the member's needs, may provide the service. The member, parent, guardian or attorney-in-fact under a durable power of attorney for health care shall be responsible for selecting the individual or agency that will provide the components of the CDAC services to be provided.

The CDAC service may include assistance with non-skilled and skilled services. The skilled services must be done under the supervision of a professional registered nurse or licensed therapist working under the direction of a physician. The registered nurse or therapist shall retain accountability for actions that are delegated.

Skilled services may include, but are not limited to:

- ◆ Tube feedings,
- ◆ Intravenous therapy,
- ◆ Parenteral injections,
- ◆ Catheterizations,
- ◆ Respiratory care,
- ◆ Care of decubiti and other ulcerated areas,
- ◆ Rehabilitation services,
- ◆ Colostomy care,
- ◆ Care of out of control medical conditions,
- ◆ Postsurgical nursing care,

- ◆ Monitoring medications,
- ◆ Preparing and monitoring response to therapeutic diets, and
- ◆ Recording and reporting of changes in vital signs.

Non-skilled services may include, but are not limited to:

- ◆ Dressing,
- ◆ Hygiene,
- ◆ Grooming,
- ◆ Bathing supports,
- ◆ Wheelchair transfer,
- ◆ Ambulation and mobility,
- ◆ Toileting assistance,
- ◆ Meal preparation,
- ◆ Cooking,
- ◆ Eating and feeding,
- ◆ Housekeeping,
- ◆ Medications ordinarily self-administered,
- ◆ Minor wound care,
- ◆ Employment support,
- ◆ Cognitive assistance,
- ◆ Fostering communication, and
- ◆ Transportation.

This service is only appropriate if the member, parent, guardian, or attorney-in-fact under a durable power of attorney for health care has the ability to and is willing to manage all aspects of the service.

Where: In the member's home or community. Not in the provider's home.

Does not include: The following are not included:

- ◆ Daycare
- ◆ Respite
- ◆ Room and board
- ◆ Case management
- ◆ Supervision

CDAC cannot replace a less expensive service.

An individual CDAC provider cannot be the recipient of respite services provided on behalf of a member receiving HCBS elderly services.

The cost of nurse supervision, if needed.

Unit: A unit is 15 minutes.

Maximum units: The case manager or MCO CBCM, working with the member and the interdisciplinary team, establishes a dollar amount that may be used for CDAC. The amount is then entered into the comprehensive service plan along with information about other HCBS services the member may receive. This monetary information is also entered into the service plan, along with the responsibilities of the member and the provider, and the activities for which the provider will be reimbursed.

The member and the provider come to an agreement on the cost per unit. A completed copy of the agreement is distributed to the member, the provider, and the case manager or MCO CBCM. The agreement becomes part of the comprehensive service plan. These steps must be completed **before** service provision.

The case manager and MCO CBCM should be aware of and have knowledge of the specific services included in the assisted living facility contract to ensure the following:

- ◆ That assisted living facility services are not duplicative of CDAC services.
- ◆ Knowledge of how the member's needs are being addressed.
- ◆ Awareness of the member's unmet needs that must be included in the comprehensive service plan.
- ◆ CDAC payment does not include the cost of room and board.
- ◆ Each member must be determined by Iowa Medicaid Enterprise to meet nursing level of care.
- ◆ The CDAC fee is calculated based on the needs of the member and may differ from individual to individual.

Provider enroll: The provider must be enrolled with the Department and certified as a CDAC provider before the completion of the *HCBS Consumer-Directed Attendant Care Agreement*.

It may be important for the member to enlist more than one CDAC provider. Back up services may be necessary in case of an emergency.

Emergency Response System

What: An electronic device connected to a 24-hour staffed system which allows the member to access assistance in the event of an emergency.

Where: The emergency response system is based in the member's home and includes an electronic device used by the member.

Unit: A unit is a one-time installation fee **and/or** one month of service.

Maximum units: 12 months of service per state fiscal year (July 1 – June 30).

Home and Vehicle Modification (HVM)

What: Physical modifications to the home or vehicle to assist with the health, safety, and welfare needs of the member and to increase or maintain independence. Competitive bids are essential to determine the cost effectiveness of the requested item. All modification requests are reviewed individually and a determination is made regarding the appropriateness of the modification request.

Where: In or on the member's home or vehicle. **Please note that only the following modifications are included:**

- ◆ Kitchen counters, sink space, and cabinets
- ◆ Special adaptations to refrigerators, stoves, and ovens
- ◆ Bathtubs and toilets to accommodate transfer, special handles and hoses for showerheads, water faucet controls, and accessible shower and sink areas
- ◆ Grab bars and handrails
- ◆ Turnaround space adaptations
- ◆ Ramps, lifts, and door, hall, and window widening
- ◆ Fire safety alarm equipment specific for disability
- ◆ Voice activated, sound activated, light activated, motion activated, and electronic devices directly related to the member's disability
- ◆ Vehicle lifts, driver specific adaptations, remote start systems, including such modifications already installed in a vehicle
- ◆ Keyless entry systems
- ◆ Automatic opening device for home or vehicle door
- ◆ Special door and window locks
- ◆ Specialized doorknobs and handles
- ◆ Plexiglas replacement for glass windows
- ◆ Modification of existing stairs to widen, lower, raise or enclose open stairs
- ◆ Motion detectors
- ◆ Low pile carpeting or slip resistant flooring
- ◆ Telecommunications device for people who are deaf
- ◆ Exterior hard surface pathway
- ◆ New door opening
- ◆ Pocket doors
- ◆ Installation or relocation of controls, outlets, and switches
- ◆ Air conditioning and air filtering if medically necessary
- ◆ Heightening of existing garage door opening to accommodate modified van

Does not include: The following are not included:

- ◆ Modifications that increase the square footage of the home
- ◆ Items for replacement that are the responsibility of the homeowner or landlord
- ◆ Vehicle purchase
- ◆ Fences
- ◆ Furnaces
- ◆ Modifications or adaptations available through regular Medicaid

Unit: A unit is the cost of the completed modification or adaptation.

Maximum: The maximum lifetime benefit is \$1,061.11. This is not included in the monthly total.

Home Delivered Meals

What: Home-delivered meals are prepared outside of the member's home and delivered to the member.

Each meal must ensure that the member receives a minimum of one-third of the daily-recommended dietary allowance as established by the Food and Nutrition Research Council of the National Academy of Sciences. Each meal may also be a liquid supplement, which meets the minimum one-third standard.

When a restaurant provides home-delivered meals, a nutritional consultation must be completed. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the client and explain what constitutes the minimum one-third daily dietary allowance. Members must inform their case manager or MCO CBCM and provider of home-delivered meals immediately if they no longer need the service.

Where: Delivered to the member's home

Unit: A unit is one meal.

Maximum: 14 meals may be delivered during any week; a maximum of two meals per day
units: No morning, noon, evening or liquid supplemental meal can be duplicated on any day.

Home Health Aide (HHA)

What: Unskilled medical services that provide direct personal care. This service may include:

- ◆ Observation and reporting of physical or emotional needs;
- ◆ Assisting with bathing, shampoo, oral hygiene, toileting and ambulation;
- ◆ Helping individuals in and out of bed;
- ◆ Reestablishing activities of daily living;
- ◆ Assisting with oral medications ordinarily self-administered and ordered by a physician; and
- ◆ Performing incidental household services, which are essential to the individual's health care at home and are necessary to prevent or postpone institutionalization, in order to complete a full unit of service.

Home health aide as a waiver service may be accessed **after** accessing services under the Medicaid state plan.

Where: In the member's home. Not in the provider's home.

Does not include: Homemaker services such as cooking and cleaning or services which meet the intermittent guidelines.

May not duplicate any regular Medicaid or waiver services provided under the state plan.

Medicaid intermittent coverage: Regular Medicaid provides for intermittent coverage of skilled nursing and home-health aide services provided in the person's home for both children and adults. Services are usually provided two to three hours per day for two to three days per week. Intermittent skilled nursing coverage includes visits up to five days per week and daily or multiple daily visits for wound care or insulin injections. Intermittent home-health aide coverage includes visits twice per day up to seven days per week for persons attending school or working or when ordered by the physician and included in the plan of care, not to exceed 28 hours per week.

Unit: A unit is a visit.

Homemaker

What: Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance. Homemaker service is limited to the following components:

- ◆ Essential shopping. Shopping for basic needs such as food, clothing, personal care items or drugs.
- ◆ Limited housecleaning. Maintenance cleaning such as:
 - Vacuuming,
 - Dusting,
 - Scrubbing floors,
 - Defrosting refrigerators,
 - Cleaning stoves,
 - Cleaning medical equipment,
 - Washing and mending clothes,
 - Washing personal items used by the member, and
 - Washing dishes.
- ◆ Meal preparation. Planning and preparing balanced meals.

Where: In the member's home and community. Not in the provider's home.

Unit: A unit is 15 minutes.

Mental Health Outreach

What: Services provided in a member's home to identify, evaluate, and provide treatment and psychosocial support. The services can be provided only on the basis of a referral from case management.

Where: In the member's home. Not in the provider's home.

Unit: A unit is 15 minutes.

Nursing Care

What: Nursing care services are provided by a licensed nurse. The services are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include:

- ◆ Observation;
- ◆ Evaluation;
- ◆ Teaching;
- ◆ Training;
- ◆ Supervision;
- ◆ Therapeutic exercise;
- ◆ Bowel and bladder care;
- ◆ Administration of medication;
- ◆ Intravenous, hypodermoclysis, and enteral feedings;
- ◆ Skin care;
- ◆ Preparation of clinical and progress notes;
- ◆ Coordination of services; and
- ◆ Informing the physician and other personnel of changes in the member's condition and needs.

Where: In the member's home. Not in the provider's home.

Does not include: Nursing services provided outside of the home or services that meet the intermittent guidelines

Medicaid intermittent coverage: Regular Medicaid provides for intermittent coverage of skilled nursing and home-health aide services provided in the person's home for both children and adults. Services are usually provided two to three hours per day for two to three days per week. Intermittent skilled nursing coverage includes visits up to five days per week and daily or multiple daily visits for wound care or insulin injections.

Intermittent home-health aide coverage includes visits twice per day up to seven days per week for persons attending school or working or when ordered by the physician and included in the plan of care, not to exceed 28 hours per week.

Unit: A unit is 15 minutes.

Maximum units: Intermediate level of care: Eight nursing visits per month.
Skilled level of care: No maximum number of visits per month.

Nutritional Counseling

What: Nutritional counseling for a severe nutritional problem or condition, which is beyond standard medical management.

Where: In the member's home or provider's office.

Unit: A unit is 15 minutes.

Respite

What: Respite care services are services provided to the member that gives temporary relief to the usual caregiver and provides all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- ◆ **Specialized respite** means respite provided on a staff-to-member ratio of one-to-one or higher for individuals with specialized medical needs requiring monitoring or supervision provided by a licensed registered nurse or licensed practical nurse.
- ◆ **Group respite** means respite provided on a staff-to-member ratio of less than one-to-one.
- ◆ **Basic individual respite** means respite provided on a staff-to-member ratio of one-to-one or higher for individuals without specialized medical needs that would require care by a licensed registered nurse or licensed practical nurse.

Where: Respite may be provided in:

- ◆ The member's home,
- ◆ Another family's home,
- ◆ Camps,
- ◆ Organized community programs (YMCA, recreation centers, senior citizens' centers, etc.),
- ◆ ICF/ID,
- ◆ RCF/ID,
- ◆ Hospital,
- ◆ Nursing facility,
- ◆ Skilled nursing facility,
- ◆ Assisted living program,
- ◆ Adult day care center,
- ◆ Foster group care,
- ◆ Foster family home, or
- ◆ DHS licensed daycare.

Respite provided outside the member's home or outside a facility in locations covered by the facility's licensure, certification, accreditation, or contract must be approved by the parent, guardian, or primary caregiver and interdisciplinary team, and must be consistent with the way the location is used by the general public. Respite in these locations may not exceed 72 continuous hours.

Does not include: Services shall not be reimbursable if the living unit is otherwise reserved for persons on a temporary leave of absence.

Respite **cannot** be provided to members residing in the family, guardian, or usual caregiver's home during the hours in which the usual caregiver is employed unless it is in a camp setting.

Respite shall not be simultaneously reimbursed or provided with duplicative services under the waiver.

Unit: A unit is 15 minutes.

Maximum units: 14 consecutive days of 24-hour respite care may be reimbursed. **and**

Respite services provided to 3 or more individuals for a period exceeding 24 consecutive hours for individuals who require nursing care because of a mental or physical condition must be provided by a licensed health care facility as described in the Iowa Code chapter 135C.

Senior Companions

What: A companion who provides non-medical care supervision, oversight, and respite. Senior companions may assist with such tasks as meal preparation, laundry, shopping, and light housekeeping tasks.

Where: In the member's home. Not in the provider's home.

Does not include: Hands-on nursing or medical care

Unit: A unit is 15 minutes.

Transportation

What: Transportation services for members to:

- ◆ Conduct business errands,
- ◆ Complete essential shopping,
- ◆ Receive medical services not reimbursed through non-emergent medical transportation, and
- ◆ Reduce social isolation.

Where: In the community as identified in the comprehensive service plan.

Unit: The units are per mile **or** per one way trip.

Consumer Choices Option

What: The **Consumer Choices Option (CCO)** is available under the elderly waiver. This option offers more control over a targeted amount of Medicaid dollars. The member will use these dollars to develop an individual budget plan to meet the member's needs by directly hiring employees and purchasing other goods and services.

CCO offers more choice, control, and flexibility over your services, as well as, more responsibility. Additional assistance is available if you choose this option. You will choose an Independent Support Broker who will help you develop your individual budget and help you recruit employees.

You will also work with a financial management service that will manage your budget for you and pay your workers on your behalf. Contact your case manager for more information. Additional information may also be found at the website: <http://dhs.iowa.gov/ime/members/medicaid-a-to-z/consumer-choices-option>.

Services that may be included in the individual budget under CCO are:

- ◆ Assistive devices
- ◆ Chore services
- ◆ Consumer-directed attendant care attendant (unskilled)
- ◆ Home and vehicle modification
- ◆ Home-delivered meals
- ◆ Homemaker services
- ◆ Basic individual respite care
- ◆ Senior companion
- ◆ Transportation

Where: In the member's home or community. Not in the provider's home.

Does not include: CCO cannot be used to pay for:

- ◆ Room and board
- ◆ Workshop services
- ◆ Other childcare
- ◆ Personal entertainment items

CCO funds cannot be used to pay for goods and services otherwise provided through Medicaid state plan services. Goods and services would:

- ◆ Decrease the need for other Medicaid services;
- ◆ Promote inclusion in the community; or
- ◆ Increase your safety in your home and community.

Unit: A monthly budget amount is set for each member.

Application Process

The application process for the elderly waiver requires a coordinated effort between the Department of Human Services (DHS) and non-department agencies on behalf of the prospective member. If you are currently working with DHS personnel, please contact that person regarding the application process.

Please respond immediately to correspondence from an income maintenance (IM) worker, case manager or MCO CBCM. This will decrease the amount of time needed to complete the application process and assist in communication.

1. Application for Medicaid (Title XIX) and the elderly waiver is made with an IM worker at the local DHS office. The documentation requested to bring may include:
 - ◆ Financial records
 - ◆ Title XIX card
 - ◆ Letter of Medicaid eligibility
 - ◆ Verification of Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI) or State Supplemental Assistance (SSA) eligibility, if applicable. If assistance is not currently being received, a request may be made to apply at the local Social Security office.
2. The applicant will be contacted to schedule an assessment. The assessment must be completed as one of the eligibility requirements for the waiver. The assessor will send the completed assessment to IME Medical Services. IME Medical Services will review the submitted documentation and make a determination as to whether or not the applicant meets the level of care.
3. IME Medical Services will review the HCBS assessment to determine if member needs require intermediate or skilled level of care.

If the member does not meet level of care, the IM worker will send a *Notice of Decision (NOD)* notifying the member of the denial. The member has the right to appeal the decision. The appeal process is explained on the *NOD*.
4. An assessment must be completed annually. If the member is enrolled with an MCO, then the MCO will make the annual level of care determination after the assessment is completed. If the member is FFS, then IME will make the annual level of care determination after the assessment is completed.
5. An interdisciplinary team meeting is conducted to determine the services that are needed, the amount of service to be provided, and the providers of the services. The interdisciplinary team meeting will be attended by the member, the case manager or DHS service worker, and other support persons the member may choose to attend. The end result of the interdisciplinary team decisions will be a comprehensive service plan developed by the case manager or DHS service worker.
6. The case manager's dated signature on the comprehensive service plan indicates the member's approval for elderly waiver services.

Discrimination is Against the Law

The Iowa Department of Human Services (DHS) complies with applicable federal civil rights laws to provide equal treatment in employment and provision of services to applicants, employees, and clients and does not discriminate on the basis of race, color, national origin, age, disability or sex. DHS does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

DHS:

- ◆ 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 Iowa Medicaid Member Services at 1-800-338-8366.

If you believe that DHS 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: DHS, Office of Human Resources, by emailing contactdhs@dhs.state.ia.us or in writing to:

DHS Office of Human Resources
Hoover State Office Building, 1st floor
1305 East Walnut Street
Des Moines, IA 50319-0114

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the DHS Office of Human Resources 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 **1-800-338-8366 (TTY: 1-800-735-2942)**.

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 **1-800-338-8366 (TTY: 1-800-735-2942)**。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-338-8366 (TTY: 1-800-735-2942)**.

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite **1-800-338-8366 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-735-2942)**.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-338-8366 (TTY: 1-800-735-2942)**.

(ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالجمان. اتصل برقم **1-800-338-8366** (رقم هاتف الصم والبكم: **1-800-735-2942**).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ **1-800-338-8366 (TTY: 1-800-735-2942)**.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-338-8366 (TTY: 1-800-735-2942)** 전화해 주십시오.

ध्यान द : य द आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। **1-800-338-8366 (TTY: 1-800-735-2942)** पर कॉल कर ।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-338-8366 (ATS: 1-800-735-2942)**.

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprouch. Ruf selli Nummer uff: Call **1-800-338-8366 (TTY: 1-800-735-2942)**.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-338-8366 (TTY: 1-800-735-2942)**.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-338-8366 (TTY: 1-800-735-2942)**.

ဟ်သုဉ်ဟ်သး- နမ့ၢ်ကတိၤ ကညီၤ ကျိၣ်အသိၣ်, နမ့ၢ်န့ၢ် ကျိၣ်အတၢ်မၤစၢၤလၢ တလၢဟ်သုဉ်လၢဟ်စ့ၤ နီတံၤဘၣ်သ့န့ၣ်လီၤ. ကိး **1-800-338-8366 (TTY: 1-800-735-2942)**.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-338-8366 (телетайп: 1-800-735-2942)**.