Department of HUMAN SERVICES

Home- and Community-Based Services
AIDS/HIV Waiver
Information Packet

The Medicaid Home- and Community-Based Services Acquired Immunodeficiency Syndrome/ Human Immunodeficiency Virus Waiver (HCBS AIDS/HIV) 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.

In addition to home and community-based waiver services, the AIDS/HIV Waiver enrolled members have access to Medicaid covered services and benefits. Medicaid covers a broad array of health services, in addition to the services provided by the waiver, limits out-of-pocket costs. These include, but not limited to, primary care, behavioral health services, skilled nursing care, dental, vision, and emergency care. Most of Iowa's Medicaid members are served by the managed care program called IA Health Link. Managed care organizations coordinate your care.

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

- AIDS/HIV services are individualized to meet the needs of each member. The following services are available:
  - Adult day care
  - Consumer-directed attendant care
  - Counseling services
  - Home delivered meals
  - Home health aide
  - Homemaker services
  - Nursing care
  - Respite
  - Consumer choices option
- The services that are considered necessary and appropriate to meet the member's needs will be determined through an interdisciplinary team consisting of the member, DHS Case Manager or Community-based Case Manager, AIDS/HIV waiver service providers, and other persons the member chooses.
- All members will have an individual service plan developed by a DHS Case Manager or Community-based Case Manager in cooperation with the member. This plan must be completed, signed, and dated before the implementation of services. The individual service plan for members **aged 20 or under** must be developed or reviewed taking into consideration those services that may be provided through the individual education plan (IEP) and Early Periodic Screening, Diagnosis and Treatment (EPSDT or Care for Kids) plans.
- Members shall access all other services for which they are eligible and which are appropriate to meet their needs as a precondition of eligibility for the AIDS/HIV waiver.
- An individual service plan must be developed and reviewed annually with the interdisciplinary team and signed and dated by the DHS Case Manager or Community-based Case Manager.
- The member must choose HCBS services as an alternative to institutional services.
- In order to receive AIDS/HIV waiver services, an approved AIDS/HIV waiver service provider must be available to provide those services.
- AIDS/HIV waiver services cannot be provided when the member is an inpatient of a medical institution.
- Members must need and use one of the available AIDS/HIV waiver services during each quarter of the calendar year.
- The total monthly cost of HCBS AIDS/HIV waiver services cannot exceed $ 1,943.43.per month.
- A designated number of members (payment slots) are designated to be served under the HCBS AIDS/HIV program.
- A Medicaid waiver service cannot be simultaneously reimbursed with another Medicaid waiver service or a Medicaid service.
- The combined total cost of AIDS/HIV waiver services and Medicaid services shall not exceed the average cost of the member's level of care provided in a medical institution.

- AIDS/HIV waiver services are available to both children and adults.
- Following is the hierarchy for accessing waiver services:
  1. Private insurance
  2. Medicaid and/or EPSDT (Care for Kids)
  3. AIDS/HIV waiver services in-home health-related care
- In addition to services available through the AIDS/HIV waiver, assistance may be available through the In-Home Health-Related Care program and or the Rent Subsidy Program through the Iowa Finance Authority. Members may contact the Iowa Finance Authority at 1-800-432-7230.

Member Eligibility Criteria

Members may be eligible for HCBS AIDS/HIV 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 diagnosed by a physician as having AIDS or HIV infection. The Iowa Medicaid Medical Services Unit is responsible for contacting the physician to establish the diagnosis. A determination of disability is not required.
- Be determined eligible for Medicaid (Title XIX). Members may be 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 Medical Services to need nursing facility or hospital level of care.

Service Descriptions

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

Adult Day Care

What: Adult day care is an organized program of supportive care in a group environment. The care is provided to members who need a degree of supervision and assistance on a regular or intermittent basis in a day care center.

Where: In an adult day program

Unit: A unit is one hour **or** half day (2 to 4 hours) **or** full day (4 to 8 hours) **or** extended day (8 to 12 hours)

Consumer-Directed Attendant Care (CDAC)

What: Assistance to the member with self-care tasks that 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, or guardian 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 medical conditions out of control,
- 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.

A determination must be made regarding what services will benefit and assist the member. Those services will be recorded in the *HCBS Consumer-Directed Attendant Care Agreement*, form 470-3372. This *Agreement* becomes part of the individual service plan developed for the member and must be signed and dated by the member, the CDAC provider, and the DHS Case Manager or Community-based Case Manager.

This service is only available 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: Daycare, baby-sitting, respite, room and board, parenting or supervision. CDAC cannot replace a less expensive service.

A CDAC provider may not be the spouse of the member or a parent or stepparent of a member aged 17 or under.

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

The cost of nurse supervision, if needed.

Unit: A unit is 15 minutes.

Maximum units: The DHS Case Manager or Community-based Case Manager, 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 individual service plan along with information about other HCBS services the member may receive. This monetary information is also entered into the *HCBS Consumer-Directed Attendant Care Agreement*, form 470-3372, 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 agreement on an hourly or daily billing unit and the cost per unit. A completed copy of the *Agreement* is signed and dated and then distributed to the member, the provider, and the Case Manager or Community-based Case Manager. The *Agreement* becomes part of the individual service plan. These steps must be completed **before** service provision.

When CDAC is provided by an assisted living facility, please note the following:

- The Case Manager or Community-based Case Manager 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 member needs are being addressed
  - Awareness of member unmet needs that must be included in the individual service plan
- CDAC payment does not include costs of room and board

- Each member must be determined by IFMC to meet nursing facility or hospital 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's fiscal agent 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.

Billing: The member, as well as the provider must sign and date the *Claim for Targeted Medical Care* before it is submitted for payment. This verifies that the services were provided as shown on the billing form.

Counseling Services

What: Counseling services are face-to-face mental health services to facilitate home management of the member and prevent institutionalization. Counseling services may be provided to the member's caregiver only when included in the individual service plan for the member. Counseling services are non-psychiatric services necessary for the:

- Management of depression,
- Assistance with a grief process,
- Alleviation of psychosocial isolation, and
- Support in coping with disability or illness, including terminal illness.

Where: A community mental health center or other location used by a provider that meets accreditation under the Mental Health and Disabilities Commission

Unit: A unit is:
Individual counseling for the member or the member and their caregiver – 15-minute increment
OR
Group counseling – 15 minutes

Payment for group counseling is based on the group rate divided by six or, if the number of persons who comprise the group exceeds six, the actual number of a person which comprises the group.

Home Delivered Meals

What: Home-delivered meals are meals 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 Board of the National Research Council of the National Academy of Sciences. Each meal may also be a liquid supplement, which meets the minimum one-third standard. **Members must inform their DHS Case Manager or Community-based Case Manager and provider of home-delivered meals immediately if they no longer need the service.**

Where: Delivered to the home

Unit: A unit is one meal.

Maximum: Fourteen meals may be delivered during any week.

Home Health Aide Services (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,
- Performing incidental household services that 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 or those provided under the EPSDT authority.

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 individual service plan, not to exceed 28 hours per week.

Before accessing the waiver, the DHS Case Manager or Community-based Case Manager must determine if there are other services the members is eligible for including EPSDT (Care for Kids) program. EPSDT services for persons under age 21 only include private duty nursing and personal care services which meet the definition of medical necessity as provided by CMS for EPSDT. Services may be provided to a child outside of the child's residence when normal life activities take the child outside the residence.

Services not covered by EPSDT include:

- Services to children with Medicaid HMO coverage
- Mental health services to children enrolled in the Iowa Plan
- Well child care
- Respite
- Transportation
- Homework assistance
- Services to other household members

Unit: A unit is a visit.

Homemaker Services

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,
- Limited house cleaning,
- Accompaniment to medical or psychiatric services,
- Meal preparation, and
- Bathing and dressing for self-directing members.

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

Unit: A unit is 15 minutes.

Nursing Services

What: A licensed nurse employed by an agency provides nursing services. The services are ordered by and included in the plan of treatment established by the physician. The services shall be based on the medical necessity of the member and the Iowa Board of Nursing scope of practice guidelines.

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 or those provided under the EPSDT authority

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 individual service plan, not to exceed 28 hours per week.

EPSDT (Care for Kids) program: EPSDT services for persons under age 21 only include private duty nursing and personal care services that meet the definition of medical necessity as provided by CMS for EPSDT. Services may be provided to a child outside of the child's residence when normal life activities take the child outside the residence.

Services not covered by EPSDT include:

- Services to children with Medicaid HMO coverage
- Mental health services to children enrolled in the Iowa Plan
- Well child care
- Respite
- Transportation
- Homework assistance
- Services to other household members

This nursing service shall not be simultaneously reimbursed with other Medicaid services. Exception: Payment may be made for supervisory visits when a registered nurse, acting in a supervisory capacity, provides supervisory visits of services provided by a home-health aide under a home-health agency plan of treatment.

Unit: A unit is a visit.

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. Services are limited by the monthly maximum available for all waiver services.

Maximum Units: Fourteen 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.

Consumer Choices Option

What: The **Consumer Choices Option (CCO)** is an option that is available under most HCBS waivers. This option will give you more control over a targeted amount of Medicaid dollars. You will use these dollars to develop an individual budget plan to meet your 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 DHS Case Manager or Community-based 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:

- Consumer-directed attendant care (unskilled)
- Home and vehicle modification
- Home delivered meals
- Homemaker
- Basic respite

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

Unit: A monthly budget amount is set for each member

Application Process

The application process for the AIDS/HIV waiver requires a coordinated effort between 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 worker or a Case Manager or Community-based Case Manager. 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 AIDS/HIV waiver is made with an income maintenance worker (IM) at the local DHS office.

   For adults applying for the AIDS/HIV waiver, an appointment will be scheduled with the IM worker. For children applying for this waiver, telephone contact will be made to the family home. Documentation necessary to complete this contact 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. An assessment tool, the interRAI is completed by the Medicaid Core Standardized Assessment Contractor or the Managed Care Organization (MCO).
3. Iowa Medicaid Medical Services will review the assessment tool to determine if member needs require ICF/ID, skilled nursing or ICF (nursing) level of care.
4. 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.
5. An interdisciplinary team meeting will be 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 DHS Case Manager or Community-based Case Manager, AIDS/HIV waiver service providers, legal representatives, and other support persons the member may choose to attend. The end result of the interdisciplinary team decisions will be an individual service plan developed, signed, and dated by the DHS Case Manager or Community-based Case Manager.
6. The Individualized Services Information System (IoWANS) process must be completed with the culmination of an approved comprehensive service plan before the implementation of services. An approved comprehensive service plan recorded in the IoWANS system authorizes payment for AIDS/HIV waiver services.
7. For MCO enrolled members, the MCO must approve the comprehensive service plan and authorize services.
8. The Case Manager or Community-based Case Manager will issue a *Notice of Decision* if the member is approved to receive AIDS/HIV waiver services.

Estate Recovery

Estate recovery legal reference: 441 IAC 75.28(7)

Estate recovery applies to all persons who have received Medicaid on or after July 1, 1994, and are age 55 or older, or who live in a medical facility and cannot reasonably be expected to return home. This includes members on waiver programs such as the Elderly Waiver Program and Medically Needy Program.

When a Medicaid member dies, assets from their estate are used to reimburse the state for costs paid for medical assistance. This includes the full amount of capitation payments made to a Managed Care Organization (MCO) for medical and dental coverage, regardless of service use or how much the managed care entity paid for services.

Additional information may also be found at the website:
https://dhs.iowa.gov/ime/members/members-rights-and-responsibilities/estate-recovery

or contact:

Medicaid Member Services Toll Free: 800-338-8366
515-256-4606 (Des Moines area)
or
Iowa Estate Recovery Program Toll Free: 1-877-463-7887
8:00 a.m. – 5:00 p.m., Monday – Friday

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).**

مكبلاو:***1-800-735-2942***). ةظوحلم: اذإ تنك ثدحتت ركذا ةغلاا، نإف تامدخ ةدعاسملا ةيوغللا رفاوتت كل ناجملاب. لصتا مقرب ***1-800-338-8366*** (مقر فتاه مصلا

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **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 [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. 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).**

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤန့ၣ် ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. 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**).