Health Care Directives

PrimeWest HEALTH™

Dear PrimeWest Health Member:

If a time comes when someone close to you has to make health care decisions on your behalf, would they know what you want?

One way to make your wishes known is through a ***Health Care Directive***. A ***Health Care Directive*** is a document you create as a way to plan for decisions about your health care that need to be made if you become severely ill and lose your ability to make these decisions. Inside are questions and answers about ***Health Care Directives***.

One of your basic rights is the right to make decisions about your health care. This includes the right to accept or refuse care after you are told about the options available. State law requires that PrimeWest Health tell you these rights when you enroll.

PrimeWest Health has written policies and procedures that make sure your rights regarding ***Health Care Directives*** are protected. Specifically, PrimeWest Health cannot condition or refuse treatment or otherwise discriminate against you based on whether or not you have a ***Health Care Directive***. PrimeWest Health expects providers to comply with your wishes to the fullest extent possible within reasonable medical practice.

Filling out a ***Health Care Directive*** form formalizes your advance health care decisions. A form that meets State of Minnesota requirements is included in this folder. Call PrimeWest Health Member Services at **1-866-431-0801** if you need additional forms. TTY users call **1-800-627-3529** or **711**. These calls are free.

If you have questions, be sure to discuss them with your health care provider.

Sincerely,

PrimeWest Health

Questions & Answers about *Health Care Directives*

Minnesota law allows you to inform others of your health care wishes. You have the right to state your wishes and appoint an agent in writing so others know what you want if you can't tell them because of illness or injury. The information in this document is about ***Health Care Directives*** and how to prepare them. **It does not give every detail of the law**.

How to Get More Information

If you want more information about ***Health Care Directives***, please contact your health care provider, your attorney, or the Minnesota Board on Aging's Senior LinkAge® Line at **1-800-333-2433**. The call is free. You can use the Minnesota Health Care Directive Planning Toolkit to help you create your ***Health Care Directive***. You can find it online at **https://extension.umn.edu/health-care/minnesota-health-care-directive-planning-toolkit**. A ***Health Care Directive*** form is also included in this folder.

PW_2007_035R_11-23/DHS_Approved_01/19/2024

What is a *Health Care Directive*?

A ***Health Care Directive*** is a written document that informs others of your wishes about your health care. It allows you to name a person ("agent") to decide for you if you are unable to decide. It also allows you to name an agent if you want someone else to decide for you. You must be at least 18 years old to make a ***Health Care Directive***.

Why have a *Health Care Directive*?

A ***Health Care Directive*** becomes important if your attending physician determines you can't communicate your health care choices (because of physical or mental incapacity). It is also important if you wish to have someone else make your health care decisions. In some circumstances, your directive may state that you want someone other than an attending physician to decide when you cannot make your own decisions.

Do I have to have a *Health Care Directive*? What happens if I don't have one?

You don't have to have a ***Health Care Directive***. But, writing one helps to make sure your wishes are followed.

You will still get medical treatment if you don't have a written ***Directive***. Health care providers will listen to what people close to you say about your treatment preferences, but the best way to be sure your wishes are followed is to have a ***Health Care Directive***.

How do I make a *Health Care Directive*?

There are forms for ***Health Care Directive***s. You can get them from your health care provider or attorney. You can use the Minnesota Health Care Directive Planning Toolkit to help you create your ***Health Care Directive***. You can find it online at **https://extension.umn.edu/health-care/minnesota-health-care-directive-planning-toolkit**. A ***Health Care Directive*** form is also included in this folder. You don't have to use a form, but your ***Health Care Directive*** must meet the following **requirements** to be legal:

- Be in writing and dated
- State your name
- Be signed by you or someone you authorize to sign for you, when you can understand and communicate your health care wishes
- Have your signature verified by a notary public or two witnesses
- Include the appointment of an agent to make health care decisions for you and/or instructions about the health care choices you wish to make

Before you prepare or revise your ***Directive***, you should discuss your health care wishes with your doctor or other health care provider.

What if I've already prepared a *Health Care Directive*? Is it still good?

Before August 1, 1998, Minnesota law provided for several other types of directives, including living wills, durable powers of attorney for health care, and mental health declarations. The law changed so people can use one form for all their health care instructions.

Forms created before August 1, 1998, are still legal if they followed the law in effect when written. They are also legal if they meet the requirements of the new law (described above). You may want to review any existing documents to make sure they say what you want and meet all requirements.

I prepared my *Directive* in another state. Is it still good?

Health Care Directives prepared in other states are legal if they meet the requirements of the other state's laws or the Minnesota requirements. But requests for assisted suicide will not be followed in Minnesota.

What can I put in a *Health Care Directive*?

You have many choices of what to put in your ***Health Care Directive***. For example, you may include the following:

- The person you trust as your agent to make health care decisions for you. You can name alternate agents in case the first agent is unavailable, or joint agents.
- Your goals, values, and preferences about health care
- The types of medical treatment you would want (or not want)
- How you want your agent or agents to decide
- Where you want to receive care
- Instructions about artificial nutrition and hydration

- Instructions about mental health treatments that use electroshock therapy or neuroleptic medications
- Instructions if you are pregnant
- Instructions about donation of organs, tissues, and eyes
- Funeral arrangements, including your preference for burial or cremation
- Who you would like as your guardian or conservator if there is a court action

You may be as specific or as general as you wish. You can choose which issues or treatments to deal with in your ***Health Care Directive***.

Are there limits to what I can put in my *Health Care Directive*?

There are some limits about what you can put in your ***Health Care Directive***. These are some examples:

- Your agent must be at least 18 years of age
- Your agent cannot be your health care provider, unless the health care provider is a family member or you give reasons for the naming of the agent in your ***Directive***
- You cannot request health care treatment that is outside of reasonable medical practice
- You cannot request assisted suicide

How long does a *Health Care Directive* last? Can I change it?

Your ***Health Care Directive*** lasts until you change or cancel it. As long as the changes meet the ***Health Care Directive*** requirements listed above, you may cancel your ***Directive*** by doing any of the following:

- Writing a statement saying you want to cancel it
- Destroying it
- Telling at least two other people you want to cancel it
- Writing a new ***Health Care Directive***

What should I do with my *Health Care Directive* after I have signed it?

You should inform others of your ***Health Care Directive*** and give people copies of it. You may wish to inform family members, your health care agent or agents, and your health care providers that you have a ***Health Care Directive***. You should give them a copy. It's a good idea to review and update your ***Directive*** as your needs change. Keep it in a safe place where it is easily found.

What if my health care provider refuses to follow my *Health Care Directive*?

Your health care provider generally will follow your ***Health Care Directive***, or any instructions from your agent, as long as the health care follows reasonable medical practice. But, you or your agent cannot request treatment that will not help you or which the provider cannot provide. If the provider cannot follow your agent's directions about life-sustaining treatment, the provider must inform the agent. The provider must also document the notice in your medical record. The provider must allow the agent to arrange to transfer you to another provider who will follow the agent's directions.

What if I believe a health care provider has not followed *Health Care Directive* requirements?

Complaints of this type can be filed with the Office of Health Facility Complaints at **1-800-369-7994** (this call is free) or **1-651-201-4200** (Metro area).

What if I believe a health plan has not followed *Health Care Directive* requirements?

Complaints of this type can be filed with Managed Care at **1-800-657-3793** (this call is free) or **1-651-201-5178** (Metro area).

Source: Minnesota Department of Health, "Questions and Answers about Health Care Directives," October 4, 2022, **www.health.state.mn.us/facilities/regulation/infobulletins/advdir.html**.

Minnesota Health Care Directive

Purpose of Form	Part 1. NAME AN AGENT Allows you to appoint another person (an agent) to make health care decisions if a doctor decides you are unable. Part 2. GIVE HEALTH CARE INSTRUCTIONS Allows you to give written instructions about your wishes. Part 3. MAKE THIS DOCUMENT LEGAL Requires you and others to sign and date to make this legal.

This form revokes all past living wills, Durable Powers of Attorney for Health Care, and other written advance health care directives you have signed.

My Personal Information				
	My name:			
	Address:			
	Preferred phone:	( )	Alternate phone:	( )
	Date of birth:			

Part 1. NAME AN AGENT

Agent Duties	My health care agent can: • Make health care decisions for me if I am unable to make and communicate decisions for myself • Make decisions based on my instructions in Part 2 of this document or in other documents • Make decisions based on what they know about my wishes • Act in my best interests if instructions are not available
Agent Roles	When naming my health care agent, I must choose one of the following. *Initial the line in front of the statement you prefer.*
	Act alone _____ I appoint one person to serve as my primary health care agent to make decisions for me if I am unable to make or communicate these decisions for myself. My primary agent may act alone. If my primary agent is not able, willing, or available, each alternate agent I name may act alone, in the order listed.
	Act together _____ I appoint two or more people to act together as my health care agent. My primary agent and alternate agents must act together and be in agreement when making decisions. If they are not all readily available, or if they disagree, a majority of the agents who are readily available may make decisions for me.

AGENT CONTACT INFORMATION				
My Primary Health Care Agent	I appoint:			
	Agent's name:			
	Address:			
	Preferred phone:	( )	Alternate phone:	( )
My First Alternate Health Care Agent	I appoint:			
	Agent's name:			
	Address:			
	Preferred phone:	( )	Alternate phone:	( )
My Second Alternate Health Care Agent	I appoint:			
	Agent's name:			
	Address:			
	Preferred phone:	( )	Alternate phone:	( )
Reasons for Naming a Health Care Provider	I have named as my agent a health care provider, or employee of a health care provider, who is currently (or may be in the future) providing direct care to me when decisions are needed. *Choose the option that applies:* _____That person is related to me by blood, marriage, registered domestic partnership, or adoption _____My reasons for wanting to appoint that person as my agent are: _____ _____ _____ _____ _____			
Powers of My Agent	If I am unable to decide or speak for myself, my agent has the power to: • Consent to, refuse, or withdraw any health care, treatment, service, or procedure • Stop or not start health care that is keeping or might keep me alive • Choose my health care providers • Choose where I live when I need health care and what personal security measures are needed to keep me safe • Obtain copies of my medical records and allow others to see them			

Additional Powers of My Agent	If I WANT my agent to have any of the following powers, I must initial the line in front of the statement. I also authorize my agent to: _____ Make health care decisions for me even if I am able to decide or speak for myself _____ Carry out my wishes regarding a funeral, burial, or what will happen to my body when I die _____ Make decisions about mental health treatment including electroconvulsive therapy and antipsychotic medication, including neuroleptics _____ In the event I am pregnant, determine whether to attempt to continue my pregnancy to delivery based upon my agent's understanding of my values, preferences, or instructions _____ Continue as my health care agent even if a dissolution, annulment, or termination of our marriage or domestic partnership is in the process or has been completed
Limiting the Powers of My Agent	I wish to limit the powers of my health care agent in the following way(s):

Part 2. GIVE HEALTH CARE INSTRUCTIONS (Please refer to **https://extension.umn.edu/health-care/minnesota-health-care-directive-planning-toolkit** for more information)

I give the following instructions about my health care (my values and beliefs, what I do and do not want, and/or views about medical treatments, concerns, fears, etc.):

I am attaching additional instructions concerning my health care values and preferences.

➔**Initial one line: _____ Yes _____ No**

I authorize donation of my organs, tissue, or other body parts after my death.

➔**Initial one line: _____ Yes _____ No**

Part 3. MAKE THIS DOCUMENT LEGAL

<table>
<tr><td rowspan="3">My Signature/ Mark and Date</td><td colspan="2">I agree with everything in this document and have made this document willingly.</td></tr>
<tr><td>My signature:</td><td></td></tr>
<tr><td>Date:</td><td></td></tr>
<tr><td rowspan="13">Notary Public OR Witnesses</td><td colspan="2">Notary Public</td></tr>
<tr><td colspan="2">➔NOTE: Must not be named as agent or alternate agent</td></tr>
<tr><td colspan="2">STATE OF MINNESOTA
County of_____
This document was signed or acknowledged before me
this _____ of _____, _____ by the above-named principal.
(day) (month) (year)</td></tr>
<tr><td>Signature of Notary Public</td><td></td></tr>
<tr><td colspan="2">Two Witnesses</td></tr>
<tr><td colspan="2">➔NOTE: Only one witness can be a direct care provider or employee of a provider on the day this is signed.</td></tr>
<tr><td colspan="2">This document was signed or acknowledged in my presence. I am not an agent or alternate agent in this document.</td></tr>
<tr><td>Witness 1 signature:</td><td></td></tr>
<tr><td rowspan="2">Address:</td><td></td></tr>
<tr><td></td></tr>
<tr><td>Date (month/day/year):</td><td></td></tr>
<tr><td>Witness 2 signature:</td><td></td></tr>
<tr><td rowspan="2">Address:</td><td></td></tr>
<tr><td></td></tr>
<tr><td>Date (month/day/year):</td><td></td></tr>
</table>

Minnesota Health Care Directive
Health Care Instructions Worksheet

MY HEALTH CARE GOALS

Having a sense of what is important to you can help your decision-makers make health care decisions under different and complex circumstances. Read each statement below and on a scale of "0" to "4," rate and select how important each of the health care goals are to you. In this case, "4" means "Extremely Important" and "0" means "Not Important at All." Remember reasonable medical care should always include maintaining a person's comfort, hygiene, and human dignity.

Health Care Goals	Not Important 0	1	Somewhat Important 2	3	Extremely Important 4
How Important Is Pain Control?					
• Being as comfortable and free from pain as possible					
• Having pain controlled, even if my ability to think clearly is reduced					
• Having pain controlled, even if it shortens my life					
How Important Is the Use of Life-Prolonging Treatment When:					
• I have a reasonable chance of recovering both physically and mentally (50/50+)					
• I have some physical limitations but can socially relate to those I care about					
• I can live a longer life no matter what my physical or mental health					
• I have little or no chance of doing everyday activities I enjoy					
• I am not able to socially relate to those I care about					
• I have a terminal illness and treatment will only prolong when I die					
• I have severe and permanent brain injury and there is little chance of regaining consciousness					
• I have severe dementia or confusion and my condition will only get worse					
How Important Are Finances and Health Care?					
• Having my wishes followed regardless of whether or not my finances are exhausted					
• Not being a financial burden to those around me					
• Not having my health care costs affect the financial situations of those I care about					

My Medical Treatment Preferences

It is helpful for others to know if and why you have strong feelings about certain medical treatments. Some of the more difficult medical decisions are about treatments used to prolong life, such as those listed below. Most medical treatments can be tried for a while and then stopped if they do not help. Discuss these medical treatments with a health care professional to make sure you understand what they might mean for you given your current as well as future health conditions.

Medical Procedure	When This Is Used	My Feelings about This Procedure
Intubation A Do Not Intubate (DNI) order is put on your medical record when you do not want this procedure	You are intubated when you cannot breathe on your own. A breathing tube is placed in your mouth—to your lungs—and is attached to a ventilator. You cannot talk or eat by mouth if you are intubated. For long-term needs, a tracheostomy (a breathing tube placed in your neck) may be needed.	
Nutrition support and hydration	If you cannot eat or drink by mouth, feeding solutions can provide enough nutrition to support life indefinitely. Feeding solutions can be put through a tube in your stomach, nose, intestine, or veins.	
Cardiopulmonary Resuscitation (CPR) A Do Not Resuscitate (DNR) order is put on your medical record when you do not want this procedure.	CPR is used if your heart and lungs stop working. CPR can include chest compressions, defibrillation (electric shock), medications, and/or a tube in your throat.	
Dialysis	If your kidneys are not working, a dialysis machine can be used to clean your blood. You may need to be hooked up to this machine several hours a day.	

My Religious and Spiritual Beliefs

Religious or spiritual beliefs and traditions influence how people feel about certain medical treatments, what quality of life means to them, and how they wish to be treated when they are dying or when they have died.

My decision makers should know the following about how my religious/spiritual beliefs should affect my health care:
My religion/spirituality is:
My congregation/spiritual community (name, city, state):
I wish to have my (priest/pastor/rabbi/shaman/spiritual leader) consulted. _____ **Yes** _____ **No** Contact Information (name/phone number): _____ _____

My Feelings about Quality and Length of Life

I have the following beliefs about whether life should be preserved as long as possible:
The following kinds of mental or physical conditions would make me think that medical treatment should no longer be used to keep me alive:

My Preferences for Care When Dying

If a choice is possible and reasonable when I am dying, I would prefer to receive care:

☐	At home
☐	At a hospital. Which one?
☐	At a nursing home. Which one?
☐	Through hospice services/care. Which one?
☐	From other health care providers. Which ones?
Other wishes I have about my care if I am dying:	

My Wishes about Donating Organs, Tissues, or Other Body Parts

Initial the lines that apply to you:

_____	I **DO** wish to donate organs, tissue, or other body parts when I die	
	_____	Any needed organs, tissue, or other body parts
	_____	Only the following listed organs, tissue, or body parts
Limitations or special wishes I have include:		
_____	I **DO NOT** wish to donate organs, tissue, or other body parts when I die	

My Additional Health Care Goals and Instructions

My decision-makers should also know these things about me to help them make decisions about my health care:
I am concerned about...
I have a fear of...
I hope that my end of life care will...

My Signature

I agree that these are my health care instructions and have completed this willingly.
My signature:
Date completed (month/day/year):
This worksheet is an attachment to my ***Health Care Directive***: ➔**Initial one line: _____ Yes _____ No**

PrimeWest HEALTH™

Member Services
1-866-431-0801
Monday – Friday, 8 a.m. – 8 p.m.

TTY
1-800-627-3529 or 711
These calls are free.

Website
PrimeWest.org

Address
PrimeWest Health
3905 Dakota St
Alexandria, MN 56308

1-866-431-0801 (toll free); TTY **1-800-627-3529** or **711**

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တကွ၊်. ဖဲနမ့၊်လိဉ်ဘဉ်တ၊်မၤစၢၤကလီလၢတ၊်ကကျိးထံဝဲဇဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်,ကိးဘဉ် လီတဲစိနီ၊်ဂံ၊်လၢထးအံၤန့ဉ်တကွ၊်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Civil Rights Notice

Discrimination is against the law. PrimeWest Health does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by PrimeWest Health. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

Civil Rights Coordinator
PrimeWest Health
3905 Dakota St
Alexandria, MN 56308
Toll Free: 1-866-431-0801
TTY: 1-800-627-3529 or 711
Fax: 1-320-762-8750
Email: compliance@primewest.org

Auxiliary Aids and Services: PrimeWest Health provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact PrimeWest Health at memberservices@primewest.org, or call Member Services at 1-866-431-0801 or TTY 1-800-627-3529 or 711. The call is free.**

Language Assistance Services: PrimeWest Health provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact PrimeWest Health at memberservices@primewest.org, or call Member Services at 1-866-431-0801 or TTY 1-800-627-3529 or 711. The call is free.**

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by PrimeWest Health. You may also contact any of the following agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services Office for Civil Rights (OCR)
You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the **OCR** directly to file a complaint:

Office for Civil Rights
U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Customer Response Center: Toll-free: 800-368-1019
TDD Toll-free: 800-537-7697
Email: ocrmail@hhs.gov

Minnesota Department of Human Rights (MDHR)
In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104
651-539-1100 (voice)
800-657-3704 (toll-free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)
You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- religion (in some cases)
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

1-866-431-0801 (toll free); TTY **1-800-627-3529** or **711**

ATTENTION: If you speak English, free language assistance services are available to you free of charge and without unnecessary delay. Additionally, appropriate auxiliary aids and services to provide information in accessible formats are available free of charge and in a timely manner. Please call the number above or speak to your provider. English

ትኩረት፥ አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ እርዳታ አገልግሎቶች፣ ያለ ምንም ክፍያ፣ እና ያለ ምንም መዘግየት ለእርስዎ ይገኛሉ። በተጨማሪም፣ መረጃን በተደራሽ ቅርፀቶች ለማቅረብ፣ ተገቢ ረዳት መርጃዎች እና አገልግሎቶች ከክፍያ ነጻ እና በጊዜ ይገኛሉ። እባክዎ ከላይ ባለው ቁጥር ይደውሉ ወይም አቅራቢዎን ያነጋግሩ። Amharic

تنبيه: إذا كنت تتحدث العربية، فستكون خدمات المساعدة اللغوية متاحة لك مجانًا وبدون تأخير غير ضروري. بالإضافة إلى ذلك، تتوفر المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهُل الوصول إليها مجانًا وفي الوقت المناسب. يرجى الاتصال بالرقم أعلاه أو التحدث إلى مقدم الخدمة الخاص بك. Arabic

သတိပြုပါ- သင်သည် မြန်မာဘာသာ ဘာသာစကားဖြင့် ပြောဆိုပါက၊ အခမဲ့ ဘာသာပြန်ဆိုပေးသော ဝန်ဆောင်မှုများကို မလိုလားအပ်သည့် နှောင့်နှေးကြန့်ကြာမှုတို့မရှိဘဲ အခမဲ့ ရရှိနိုင်ပါမည်။ ထို့အပြင်၊ အသုံးပြုခွင့်ရရှိထားသောပုံစံများတွင် သတင်းအချက်အလက်များ ပေးဆောင်နိုင်ရန်အတွက် သင့်လျော်သော အရန်အကူအညီများနှင့် ဝန်ဆောင်မှုများကို အချိန်နှင့်တစ်ပြေးညီ အခမဲ့ရရှိနိုင်ပါသည်။ အထက်တွင် ဖော်ပြထားသောနံပါတ်ကို ဖုန်းခေါ်ဆိုပါ သို့မဟုတ် သင်၏ဝန်ဆောင်မှုပေးသူထံ စကားပြောဆိုပါ။ Burmese

注意：如果您講繁體中文，我們將免費為您提供語言協助服務，且不會造成不必要的延誤。此外，還免費及時提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打上述電話號碼或與您的提供者聯絡。Chinese

ATTENTION : Si vous parlez Français, des services d’assistance linguistique gratuits sont à votre disposition gratuitement et sans délai inutile. En outre, des aides et services auxiliaires appropriés permettant de fournir des informations dans des formats accessibles sont disponibles gratuitement et en temps opportun. Veuillez appeler le numéro ci-dessus ou parler à votre prestataire. French

CEEB TOOM: Yog tias koj hais lus Hmoob, muaj cov kev pab cuam lus pab dawb rau koj xwb thiab tsis muaj qhov qeeb li. Dhau no lawm, tseem muaj ntaub ntawv qhia txog cov cuab yeej pab hnov lus thiab cov kev pab cuam ua hom qauv ntawv uas mus siv tau dawb yam tsis sau nqi thiab raws sij hawm. Thov hu rau tus xov tooj saum toj no los sis tham nrog koj tus kws kho mob. Hmong

တိၢ်ဒိုဉ်- ဖဲနမ့ၢ်ကတိၤကညီကျိာ်နၣ်,သဘျုကျိာ်တၢ်ဟ့ဉ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ်ကအိဉ်ဝဲဒဉ်လၢနဂီၢ်လၢတလိဉ်ဟ့ဉ်အပှၤဒီးတထုးတၢ်ဆၢကတီၢ်ဃံာ်ဃံာ်ဘဉ်နၣ်လီၤ. အမဲာ်ညါ, တၢ်နဉ်ဟူအပီးအလီလၢအဖိးမံဒီးတၢ်မၤစၢၤအ တၢ်ဖံးတၢ်မၤတဖဉ်လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤလၢကွၢ်ဂီၤလၢတၢ်မၤနှၢ်သူအီၤညီနှဉ်ကအိဉ်ဝဲဒဉ်လၢအပှၤတအိဉ်ဒီးတၢ်ကဟ့ဉ်အီၤအဆၢကတီၢ်ဘဉ်ဘဉ်နၣ်လီၤ. ဝံသးစူၤကီးဘဉ်လီတဲစိနိၢ်ဂံၢ်လၢထးမ့တမ့ၢ်ကတိၤတၢ်ဒီးနပှၤဟ့ဉ်တၢ်မၤစၢၤတၢ်တကွၢ်. Karen

1-866-431-0801 (toll free); TTY **1-800-627-3529** or **711**

ជូរកត់ចំណាំ៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃអាចរកបានសម្រាប់អ្នកដោយមិនគិតថ្លៃនិងដោយគ្មានការពន្យារពេលមិនចាំបាច់។ លើសពីនេះ ជំនួយ និងសេវាកម្មជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានក្នុងទម្រង់ដែលអាចចូលប្រើបាន អាចរកបានដោយមិនគិតថ្លៃ និងទាន់ពេលវេលា។ សូមទូរសព្ទទៅលេខខាងលើ ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។ Khmer

주의: 한국어를 사용하시는 경우, 불필요한 지연 없이 무료로 언어 지원 서비스를 받으실 수 있습니다. 또한, 접근 가능한 형식으로 정보를 제공해 주는 적절한 보조 도구와 서비스를 무료로 적시에 이용하실 수 있습니다. 위의 번호로 전화하시거나 담당 의료 제공자에게 문의해 주십시오. Korean

ຂໍ້ຄວນ ເອົາໃຈໃສ່: ຖ້າ ທ່ານ ເວົ້າ ລາວ, ການບໍລິການການ ຊ່ວຍເຫຼືອ ດ້ານພາສາ ແມ່ນມີ ໃຫ້ ທ່ານ ໂດຍບໍ່ເສຍ ຄ່າ ແລະ ໂດຍບໍ່ມີການ ຊັກ ຊ້າທີ່ບໍ່ ຈຳ ເປັນ. ນອກຈາກນັ້ນ, ການ ຊ່ວຍ ເຫຼືອ ແລະ ການບໍລິການ ສົມທີ່ເໝາະສົມໃນການສະຫນອງ ຂໍ້ມູນ ໃນຮູບແບບທີ່ສາມາດເຂົ້າ ເຖິງ ໄດ້ ແມ່ນມີ ໃຫ້ ໂດ ຍ ບໍ່ ເສຍ ຄ່າ ແລະ ທັນ ເວລາ. ກະລຸນາ ໂທ ຫາ ເບີ ໂທ ຂ້າງ ເທິງ ຫຼື ເວົ້າ ກັບ ຜູ້ ໃຫ້ ບໍລິການ ຂອງ ທ່ານ. Lao

HUBADHAA: Afaan Oromoo dubbattu yoo ta'e, tajaajilootni deeggarsa afaanii barfannaa hin barbaachisne malee bilisaan isiniif kennamu. Dabalataanis, odeeffannoo bifa argamuun danda'uun dhiyeessuf tajaajilliwwaniifi deeggarsiwwan dabalataa bilisaafi yeroosaa eeggate jira. Maaloo lakkkoofsa armaan olii irratti bilbilaa yookiin ogeessa fayyaa keessan haasofsiisaa. Oromo

ВНИМАНИЕ: Если вы говорите по-русски, вам доступны бесплатные услуги языковой помощи, которые оказываются безвозмездно и своевременно. Кроме того, бесплатно и своевременно предоставляются соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах. Позвоните по указанному выше номеру или обратитесь к своему поставщику услуг. Russian

FIIRO GAAR AH: Haddii aad ku hadasho Soomaali, adeegyada kaalmada luqadda bilaashka ah ayaa laguugu heli karaa adiga lacag la'aan oo aan lahayn daahid aan lama huraan ahayn. Intaa waxaa dheer, caawimooyinka iyo adeegyada ku habboon si loogu bixiyo macluumaadka qaabab la heli karo ayaa lagu heli karaa lacag la'aan iyo waqti ku habboon. Fadlan wac lambarka kore ama la hadal adeeg bixiyahaaga. Somali

ATENCIÓN: Si habla español, los servicios gratuitos de asistencia en otros idiomas están disponibles para usted de forma gratuita y sin demoras innecesarias. Además, se dispone de ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles de forma gratuita y oportuna. Llame al número mencionado anteriormente o hable con su proveedor. Spanish

LƯU Ý: Nếu quý vị nói Tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị, hoàn toàn miễn phí và không bị chậm trễ không cần thiết. Ngoài ra, các thiết bị và dịch vụ hỗ trợ phù hợp để cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp miễn phí và kịp thời. Vui lòng gọi số ở trên hoặc nói chuyện với nhà cung cấp của quý vị. Vietnamese