

Insert Your Logo Here

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under “Get help & more information.” You can also see Chapter 9 of the Member Handbook for information about how to make an appeal.

Notice of Denial of Payment

Date:

Member number:

Name:

<Insert other identifying information, as necessary (e.g., provider name, enrollee’s Medicaid number, service subject to notice, date of service).>

Your request was denied

We’ve *<insert appropriate term: denied, stopped, reduced, suspended>* the payment of medical services/items listed below requested by you or your doctor *<provider>*:

Why did we deny your request?

We *<insert appropriate term: denied, stopped, reduced, suspended>* the payment of medical services/items listed above because *<Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage (Member Handbook) provisions to support decision>*:

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) to review our decision by asking us for a Level 1 Appeal (sometimes called an “internal appeal” or “plan appeal”). In special cases, you can also ask for an Independent Medical Review (IMR) without first appealing to our plan. You cannot ask for an IMR if you have already had a State Hearing on the same issue. If you get an IMR and you are not satisfied with the result, you can still ask for a State Hearing.

Level 1 Appeal with IEHP DualChoice: Ask IEHP DualChoice for a Level 1 Appeal within **60 calendar days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled “How to ask for a Level 1 Appeal with IEHP DualChoice” for information on how to ask for a plan level appeal.

Independent Medical Review (IMR) for Medi-Cal Services: In most cases, you must file a Level 1 Appeal with IEHP DualChoice before requesting an IMR. You must ask for an IMR within **6 months** after IEHP DualChoice sends you a written response to your Level 1 Appeal. An IMR is a review of your case by doctors who are not part of IEHP DualChoice. If the IMR is decided in your favor, IEHP DualChoice must give you the service or item you requested. You pay no costs for an IMR. See section titled “How to ask for an Independent Medical Review” of this notice for information about how to ask for an IMR.

*How to keep your services while we review your case: If we’re stopping or reducing a service, you can keep getting the service while your case is being reviewed. **If you want the service to continue, you must ask for an appeal within 10 days** of the date of this notice or before the service is stopped or reduced, whichever is later. Your provider must agree that you should continue getting the service.*

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-877-273-IEHP (4347), 8am-8pm (PST), 7 days a week, including holidays to learn how to name your representative. TTY users call 1-800-718-4347. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You’ll need to mail or fax this statement to us. Keep a copy for your records.

Standard Appeal – We’ll give you a written decision on a standard appeal within **30 calendar days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We’ll tell you if we’re taking extra time and will explain why more time is needed. If your appeal is for payment of a service you’ve already received, we’ll give you a written decision within **60 calendar days**.

How to ask for a Level 1 Appeal with IEHP DualChoice

Step 1: You, your representative, or your provider must ask for an appeal within **60 calendar days** of getting this notice.

Your <written> request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors’ letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

We recommend keeping a copy of everything you send us for your records.

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, fax, or deliver your appeal or call us.

For a Standard Appeal:	Mailing Address:	IEHP DualChoice P.O. Box 1800 Rancho Cucamonga, CA 91729-1800
	Phone:	1-877-273-IEHP (4347)
	TTY Users Call:	1-800-718-4347
	Fax:	909-890-5748

If you ask for a standard appeal by phone, we will repeat your request back to you to be sure we have documented it correctly. We will also send you a letter confirming what you told us. The letter will tell you how to make any corrections.

What happens next?

If you ask for a Level 1 Appeal and we continue to deny your request for payment of a service, we'll send you a written decision.

If the service was originally a Medicare service or a service covered by both Medicare and Medi-Cal, we will automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.

If the service was a Medi-Cal service, you can ask for an Independent Medical Review or a State Hearing. Your written decision will give you instructions on how to request the next level of appeal. Information is also below.

How to ask for an Independent Medical Review

You can ask for an Independent Medical Review (IMR) for Medi-Cal covered services and items (not including In-Home Supportive Services) from the California Department of Managed Health Care (DMHC). You can ask for an IMR if you disagree with IEHP DualChoice's Level 1 Appeal decision or if IEHP DualChoice has not resolved your Level 1 Appeal after 30 days.

In most cases, you must file a Level 1 Appeal with IEHP DualChoice before requesting an IMR. You may be able to have an IMR without appealing to IEHP DualChoice first if:

- Your problem is urgent and involves an immediate and serious threat to your health.
- IEHP DualChoice denied a Medi-Cal service or treatment because it is experimental or investigational.
- You otherwise think that appealing to IEHP DualChoice is not in your best interest.

You cannot ask for an IMR if you have already had a State Hearing on the same issue. If you get an IMR and you are not satisfied with the result, you can still ask for a State Hearing.

Step 1: You or your representative must ask for an IMR within **6 months** after we send you a written decision. If you need help, you can call the DMHC Help Center at 1-888-466-2219. TDD users should call 1-877-688-9891.

Step 2: Fill out the online Independent Medical Review/Complaint Form available at <http://www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForm.aspx>. Or you can fill out the hard copy IMR application form that is included with this notice and send it to:

Help Center
Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
FAX: 916-255-5241

If you choose to do so, you may attach copies of letters or other documents about the service or item that was denied. If you do, send copies of documents, not originals. The DMHC Help Center may not be able to return all original documents.

What happens next?

If you qualify for an IMR, the DMHC will review your case and send you a letter within 7 days telling you that you qualify for an IMR. After your application and supporting documents are received, the IMR decision will be made within 30 days, or within 3 to 7 days if your case is urgent. Doctors who are not part of IEHP DualChoice will review your case. The DMHC will send you a letter explaining the decision. If the IMR decision is in your favor, IEHP DualChoice must give you the service or treatment you asked for. If you do not agree with the decision, you can ask for a State Hearing.

If you do not qualify for an IMR, your issue will be reviewed through DMHC's standard complaint process. You will receive a written notice of the decision within 30 days. If you decide not to use the IMR process, you may be giving up your rights under California law to pursue legal action against IEHP DualChoice about the service or treatment you are asking for.

How to ask for a State Hearing

If the service was a Medi-Cal covered service or item, you can ask for a State Hearing. You can only ask for a State Hearing after you have appealed to our health plan and received a written decision with which you disagree. Please note that if you have a State Hearing, you will not be able to ask for an Independent Medical Review.

Step 1: You or your representative must ask for a State Hearing within **120 days** of the date of our notice to you that the Level 1 appeal decision has been upheld. Fill out the "Form to File a State Hearing" that is included with this notice. Make sure you include all of the requested information.

Step 2: Send your completed form to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430
FAX: 916-651-5210 or 916-651-2789

You can also request a State Hearing by calling 1-800-952-5253 (TDD: 1-800-952-8349). If you decide to make a request by phone, you should be aware that the phone lines are very busy.

What happens next?

The State will hold a hearing. You may attend the hearing in person or by phone. You'll be asked to tell the State why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You'll get a written decision that will explain if you have additional appeal rights.

A copy of this notice has been sent to:

<Name>

<Address>

<City, State Zip Code>

Get help & more information

- Call IEHP DualChoice at 1-877-273-IEHP (4347), 8am–8pm (PST), 7 days a week, including holidays. TTY users call 1-800-718-434. You can also visit our website at www.iehp.org.
- Call the **Cal MediConnect Ombuds Program** for free help. The Cal MediConnect Ombuds Program helps people enrolled in Cal MediConnect with service or billing problems. They can talk with you about how to make an appeal and what to expect during the appeal process. The phone number is 1-855-501-3077.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Call the **Medicare Rights Center** at 1-888-HMO-9050.
- Call the **Health Insurance Counseling and Advocacy Program (HICAP)** for free help. HICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-434-0222.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- You can also see **Chapter 9 of the Member Handbook** for information about how to make an appeal.
- Call the **California Department of Managed Health Care (DMHC)** for free help. The DMHC is responsible for regulating health care service plans. If you have a complaint against your health plan, you should first telephone your health plan at **1-877-273-IEHP (4347)** and use your health plan's grievance process before contacting the DMHC. Using this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a complaint involving an emergency, a complaint that has not been satisfactorily resolved by your health plan, or a complaint that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees

If you speak other languages, language assistance services, free of charge, are available to you. Call 1-877-273-IEHP (4347), 8am–8pm (PST), 7 days a week, including holidays. TTY/TDD users should call 1-800-718-4347. The call is free.

Si usted habla otro idioma o necesita asistencia de un intérprete, tenemos disponible para usted servicios de interpretación libres de costo. Llame al 1-877-273-IEHP (4347), 8am–8pm (Hora del Pacífico), los 7 días de la semana, incluidos los días festivos. Los usuarios de TTY/TDD deben llamar al 1-800-718-4347. La llamada es gratuita.

You can get this document for free in other formats, such as large print, braille, or audio. Call 1-877-273-IEHP (4347), 8am – 8pm (PST), 7 days a week, including holidays. TTY/TDD users should call 1-800-718-4347. The call is free.

INDEPENDENT MEDICAL REVIEW APPLICATION/COMPLAINT FORM

FREE: The IMR/Consumer Complaint process is free.

FAST: IMRs are usually decided within 30 days, or within 7 days if the health issue is urgent.

SUCCESSFUL: Close to 60% of patients receive the requested service through IMR.

FINAL: Health plans must follow the IMR decision and promptly provide the service.

PATIENT INFORMATION

First Name _____ Middle Initial ____ Last Name _____

Patient's Date of Birth (mm/dd/yyyy) _____

Gender

Male Female

Name of Parent or Guardian if Filing for Minor Child:

First Name _____ Middle Initial ____ Last Name _____

Street Address _____

City _____ State ____ Zip _____

Daytime Phone # _____ Evening Phone # _____

Email Address _____

Do you want someone to help you with your complaint?

Yes No

Health Plan Name _____

Patient's Membership # _____

Medical Group Name (if enrolled in a medical group) _____

Employer _____ Not Employed

Do you have Medi-Cal?

Yes No

- If yes, have you filed a Request for a State Hearing?

Yes No

Do you have Medicare or Medicare Advantage?

Yes No

Have you filed a complaint or grievance with your health plan?

Yes No

Are you seeking payment for a service that you have already received?

Yes No

- If yes, list the dates(s) of service, and the provider's name:

Are you seeking authorization of future services?

Yes No

Do you need help with daily activities or consider yourself to have a disability?

Yes No

YOUR HEALTH PROBLEM

What is your medical condition or doctor's diagnosis? (Please be specific)

What medical treatment(s)/service(s) and/or medication(s) are you requesting? (Please be specific)

Did your health plan say the treatment you want is (check one):

Not Medically Necessary Experimental or Investigational

- Not an Emergency/Urgent Other

If other please describe _____

List the name and phone number of your primary care doctor and other providers who have seen, treated, or advised you for this condition.

Have you seen any out-of-network providers for your condition?

- Yes No

- If yes, please include the medical records with this form.

GRIEVANCE/APPEAL INFORMATION

Briefly describe the problem you are having with your plan. For example, explain if the problem is a denied treatment, an unpaid claim, trouble getting an appointment or medication, or if your coverage has been cancelled by the plan.

MEDICAL RELEASE

I request the Department of Managed Health Care (DMHC) to make a decision about my problem with my plan. I request the DMHC to review my Independent Medical Review (IMR) Application/Complaint Form to determine if my complaint qualifies for an IMR or the DMHC's Consumer Complaint process. I allow my providers, past and present, and my plan to release my medical records and information to review this issue. These records may include medical, mental health, substance abuse, HIV, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the DMHC to review these records and information and send them to my plan. My permission will end one year from the date below, except as allowed by law. For example, the law allows the DMHC to continue to use my information internally. I can end my permission sooner if I wish. All the information that I have provided on this sheet is true.

I have read and agree to the Medical Release statement above.

STATISTICAL INFORMATION ONLY

You are asked to voluntarily provide the following information. Giving this information will help the DMHC identify any patterns of problems. Health and Safety Code section 1374.30 authorizes the DMHC to obtain this information for research and statistical purposes. Giving this information is optional and will not affect the IMR or complaint decision in any way.

Primary Language Spoken _____
Race/Ethnicity Heritage _____

SIGN & SUBMIT

I declare that:

1. I am the person identified in the information above.
2. I am seeking Independent Medical Review with the Department of Managed Health Care.
3. The information entered above is correct to the best of my knowledge.
4. I understand that falsification of records or information submitted to the Department of Managed Health Care may subject me to administrative, civil, or criminal liability.

I agree that the Department of Managed Health Care will consider me to have signed my application for Independent Medical Review.

I, _____, have read and agree to the "Sign and Submit" statement above.

Date _____



DISCRIMINATION IS AGAINST THE LAW LA DISCRIMINACIÓN ES UN ACTO CONTRA LA LEY

Inland Empire Health Plan (IEHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. IEHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

IEHP:

- 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 IEHP Member Services at 1-877-273-4347 (TTY: 1-800-718-4347).

If you believe that IEHP 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:

Civil Rights Coordinator
Inland Empire Health Plan
10801 Sixth Street, Suite 120
Rancho Cucamonga, CA 91730
Telephone: 1-877-273-4347 (TTY: 1-800-718-4347)
Fax: 1-909-890-5748
Email: CivilRights@iehp.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance the Civil Rights Coordinator 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>.



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Inland Empire Health Plan (IEHP) cumple con las leyes Federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. IEHP no excluye a las personas ni las trata de forma diferente debido a su raza, color, nacionalidad, edad, discapacidad o sexo.

IEHP:

- Proporciona asistencia y servicios gratuitos a personas con discapacidad para que se comuniquen de manera eficaz con nosotros, como los siguientes:
 - Intérpretes de lenguaje de señas calificados
 - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Proporciona servicios lingüísticos gratuitos a personas que prefieren comunicarse en un idioma diferente al inglés, como los siguientes servicios:
 - Intérpretes calificados
 - Información escrita en otros idiomas

Si necesita recibir estos servicios, comuníquese con Servicios para Miembros de IEHP al 1-877-273-4347 (TTY: 1-800-718-4347).

Si considera que IEHP no le proporcionó estos servicios o lo discriminó de otra manera por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja formal ante el Coordinador de Derechos Civiles:

Civil Rights Coordinator

Inland Empire Health Plan

10801 Sixth Street, Suite 120

Rancho Cucamonga, CA 91730

Teléfono: 1-877-273-4347 (TTY: 1-800-718-4347)

Fax: 1-909-890-5748 **Correo electrónico:** CivilRights@iehp.org

Puede presentar una queja formal en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, el Coordinador de Derechos Civiles está a su disposición para ayudarle.

También puede presentar una queja de derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los Estados Unidos de manera electrónica a través del Portal de Quejas de la Oficina de Derechos Civiles, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

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)

Puede obtener los formularios de queja en el sitio web

<http://www.hhs.gov/ocr/office/file/index.html>.



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ARABIC

يلتزم IEHP بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس. ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 1-877-273-4347 (رقم هاتف الصم والبكم: 1-800-718-4347).

ARMENIAN

IEHP-ը հետևում է քաղաքացիական իրավունքների մասին գործող դաշնային օրենքներին և խտրականություն չի ցուցաբերում՝ ցեղի, մաշկի գույնի, ազգային պատկանելության, տարիքի, հաշմանդամության կամ սեռի հիման վրա: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-877-273-4347 (TTY (հեռատիպ)՝ 1-800-718-4347):

CHINESE

IEHP 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。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 1-877-273-4347 (TTY : 1-800-718-4347)。

FARSI

از IEHP از قوانین حقوق مدنی فدرال مربوطه تبعیت می کند و هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت افراد قابل نمی شود. توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-273-4347 (TTY: 1-800-718-4347) تماس بگیرید.

HINDI

IEHP लागू होने योग्य संघीय नागरिक अधिकार क़ानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है। ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-273-4347 (TTY: 1-800-718-4347) पर कॉल करें।

HMONG

IEHP ua raws cov kev cailij choj pej xeem uas yuam siv ntawm Tsom Fwv Teb Chaw (Federal civil rights laws) thiab tsis muaj kev ntxub ntxaug vim yog ibhom neeg, cev nqaij tawv, neeg keeb kwm hauv lub teb chaws, hnuv nyoog laus hluas, kev tsis taus, los sis txiv neeg los yog poj niam. LUS CEEV: Yog tias koj hais lus Hmoob, muaj kev pab txhais lus hmoob pub dawb rau koj. Hu rau 1-877-273-4347 (TTY: 1-800-718-4347).

JAPANESE

IEHP は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害または性別に基づく差別をいたしません。注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-273-4347 (TTY:1-800-718-4347) まで、お電話にてご連絡ください。

KHMER

IEHP ប្រតិបត្តិការច្បាប់សិទ្ធិស៊ីវិលនៃរដ្ឋបាលសហព័ន្ធជាធរមាន និងមិនរើសអើង យោងទៅលើជាតិសាសន៍ ពណ៌សំបុរ ដើមកំណើត អាយុ ភាពពិការ ឬភេទ ឡើយ។ ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ ទូរស័ព្ទទៅលេខ 1-877-273-4347 (TTY: 1-800-718-4347)។



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KOREAN

IEHP은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-273-4347 (TTY: 1-800-718-4347)번으로 전화해 주십시오.

PUNJABI

IEHP, ਲਾਗੂ ਫੈਡਰਲ ਸਿਵਲ ਅਧਿਕਾਰ ਕਾਨੂੰਨ ਦੀ ਪਾਲਣਾ ਕਰਦਾ ਹੈ ਅਤੇ ਨਸਲ, ਰੰਗ, ਰਾਸ਼ਟਰੀ ਮੂਲ, ਉਮਰ, ਅਪੰਗਤਾ, ਜਾਂ ਸੈਕਸ ਦੇ ਆਧਾਰ ਤੇ ਵਿਤਕਰਾ ਨਹੀਂ ਕਰਦਾ ਹੈ। ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ (Punjabi) ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-877-273-4347 (TTY: 1-800-718-4347) 'ਤੇ ਕਾਲ ਕਰੋ।

RUSSIAN

IEHP соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-273-4347 (линия TTY: 1-800-718-4347).

TAGALOG

Sumusunod ang IEHP sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-273-4347 (TTY: 1-800-718-4347).

THAI

IEHP ได้ปฏิบัติตามรัฐธรรมนูญที่ห้ามการเลือกปฏิบัติโดยไม่เป็นธรรม และไม่ได้แบ่งแยกทางชาติพันธุ์ สีผิว เชื้อชาติ อายุ ความพิการ หรือเพศ

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-273-4347 (TTY: 1-800-718-4347).

LAO

IEHP ປະຕິບັດຕາມກົດໝາຍອ່າວ ວຍສົດທິພົນລະເມືອງຂອງຮັຖບານກາງທິ ບັງຄັບໃຊ້ ແລະບໍ່ຈຳແນກໂດຍອົງໃສ່ ພື້ນຖານດ້ານເຊື້ອຊາດ, ສີ່ຜິວ, ຊາດກຳເນີດ, ອາຍຸ, ຄວາມພິການ, ຫຼື ເພດ. ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ້ນຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-877-273-4347 (TTY: 1-800-718-4347).

VIETNAMESE

IEHP tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-273-4347 (TTY: 1-800-718-4347).