OHIO DEPARTMENT OF MEDICAID

LEVEL OF CARE ASSESSMENT

I. **Demographics** Assessment Date

a. Name	b. Address			
c. Phone	d. County	e. Date of Birth	f. Age	g. Sex ☐ Male ☐ Female
h. Language Spoken Barrier ☐ Yes ☐ No				
i. Medicaid I. D. ☐ Active ☐ Pending				
j. Social Security Number	k. Medicare Number	l. Date of Conversion from other Funding to Medicaid		
m. Other Health Insurance				
n. Contact ☐ Guardian ☐ POA ☐ Authorized Rep.		o. Phone *(Day)* Phone *(Evening)*		

p. Relationship		
q. **Usual**	**Current**	**Living Arrangement**
☐	☐	☐ Own home/apartment
☐	☐	☐ Relative/friend
☐	☐	☐ Congregate housing
☐	☐	☐ Group, foster, rest home
☐	☐	☐ Nursing Facility (NF)
☐	☐	☐ (ICF/IID)
☐	☐	☐ Psychiatric hospital/unit
☐	☐	☐ Acute care hospital
☐	☐	☐ Other *(specify)*

II. Reason For Request

a. ☐ Nursing Facility (NF) Admission *(check one of the following)*

☐ New Admission ☐ Readmit: original date of admission ☐ Transfer: from original date of admission

b. ☐ ICF/IID *(name)*

c. ☐ HCBS services *(specify)*

d. ☐ Assisted Living

e. ☐ RSS

f. ☐ LOC Review

g. ☐ Other *(specify)*

If NF Admission

NF Name	NF Address	City	State	Zip Code
Estimated Length of Stay	Provider Number			

III. LOC Assessment Summary

a. ADLS *(list total to the left of category)*	☐ Independent	☐ Supervision	☐ Assistance
b. IADLS *(list total to the left of category)*	☐ Independent	☐ Supervision	☐ Assistance
c. Medication Administration	☐ Independent	☐ Supervision	☐ Assistance
d. ☐ Needs 24-hour supervision due to cognitive impairment		e. Medical Condition ☐ Stable ☐ Unstable	
f. ☐ Skilled Nursing Services *(list/frequency)*			
g. ☐ Skilled Rehabilitation Services *(list/frequency)*			

IV. Informal Support ☐ Yes ☐ No *(If yes, list and describe below)*

V. LOC Recommendation *(to be completed by PAA staff only)*

Based on review of the LOC assessment, it is recommended that the level of care indicated below is appropriate:

☐ Skilled ☐ Intermediate ☐ Intermediate/Developmental Disabilities ☐ Protective ☐ None

ID Number *(if applicable)*	Signature/Title	Initials

(To be completed by client or authorized representative) I understand my health care options and choose to receive:

☐ NF Services ☐ ICF/IID Services ☐ HCBS Waiver Services ☐ Assisted Living Services ☐ RSS

☐ Other

I authorize Medicaid or the PASSPORT Administrative Agency to release information contained within this assessment, to the following only *(check all that apply)*:

☐ Agent/Agencies providing me with services, ☐ Agent/Agencies funding services which I receive, and

☐ Agent/Agencies evaluating the effectiveness of services which I receive.

Client or Authorized Representative	Date

CERTIFICATION: I certify that I have reviewed the information contained herein, and that the information is a true and accurate reflection of the individual's condition. I certify that the level of care recommended above is required OR that the level of care checked below is required.

☐ Skilled ☐ Intermediate ☐ Intermediate/Developmental Disabilities ☐ Protective ☐ None

Certification Signature	Date

FOR PAA USE ONLY

Date of verbal authorization	PAA Assessor Signature

Client	Date

VI. Physicians *(Physician, Nurse Practitioner, or Physician Assistant)*

PRIMARY Specialty				OTHER Specialty			
Name				Name			
Address	City	State	Zip Code	Address	City	State	Zip Code
Phone	Date last seen			Phone	Date last seen		

VII. Diagnoses Source of information *(Please Check)*

☐ Physician ☐ Medical Record ☐ Record ☐ Client ☐ Caregiver ☐ Authorized Representative

	Date of Onset	ICD Code		Date of Onset	ICD Code
1) Primary			4)		
2)			5)		
3)			6)		

VIII. Health History ***(INCLUDE SUMMARY OF OVERALL CONDITION)*** Source of information *(Please Check)*

☐ Physician ☐ Medical Record ☐ Record ☐ Client ☐ Caregiver ☐ Authorized Representative

PROGNOSIS

☐ Good ☐ Fair ☐ Poor

REHABILITATION POTENTIAL

☐ Improved Function ☐ Maintain Function

☐ Delay Loss of Function ☐ None

IX. Allergies *(include medications, insects, molds, foods, animals, grasses, etc.)*

X. Medication Profile Sources of information *(Please Check)*

☐ Physician ☐ Medical Record ☐ Record ☐ Client ☐ Caregiver

☐ Authorized Representative ☐ Additional Page Included

A) Medications	RX	OTC	Dosage/ Frequency	Route	Medications *(continued)*	RX	OTC	Dosage/ Frequency	Route
1)					6)				
2)					7)				
3)					8)				
4)					9)				
5)					10)				
TOTALS					TOTALS				

B) Pharmacy	Address	City	State	Zip Code	Phone

C) Chemicals *(include frequency and amount)*

Alcohol	Caffeine
Other	Nicotine

☐ Additional Information attached on trailer sheet

Client	Date

FOR SECTIONS XI, XII, XIII AND XIV, *(Indicate assistance level for **every** activity below, do not skip any activities)*
List all sources of information for each item as follows:
P=Physician, MR=Medical Record, C=Client, CG=Caregiver, AR=Authorized Representative, AO=Assessor Observation

XI. ADL Activities of Daily Living	No Help	Super-vision	Hands On	Sources
a. Mobility				
1. Bed	☐ 1	☐ 2	☐ 3	
2. Transfer	☐ 1	☐ 2	☐ 3	
3. Locomotion	☐ 1	☐ 2	☐ 3	
b. Bathing	☐ 1	☐ 2	☐ 3	
c. Grooming	☐ 1	☐ 2	☐ 3	
d. Toileting	☐ 1	☐ 2	☐ 3	
e. Dressing	☐ 1	☐ 2	☐ 3	
f. Eating	☐ 1	☐ 2	☐ 3	
List durable, assistive and adaptive equipment used				

XII. IADL Instrumental Activities of Daily Living	No Help	Super-vision	Hands On	Sources
a. Shopping	☐ 1	☐ 2	☐ 3	
b. Meal Preparation	☐ 1	☐ 2	☐ 3	
c. Environmental				
1. House Cleaning	☐ 1	☐ 2	☐ 3	
2. Heavy Chores	☐ 1	☐ 2	☐ 3	
3. Yardwork/Maintenance	☐ 1	☐ 2	☐ 3	
d. Laundry	☐ 1	☐ 2	☐ 3	
Community Access				
1. Telephoning	☐ 1	☐ 2	☐ 3	
2. Transportation	☐ 1	☐ 2	☐ 3	
3. Legal/Financial	☐ 1	☐ 2	☐ 3	
XIII. Medication Administration	☐ 1	☐ 2	☐ 3	

List activity*(ies)* for which 24-hour supervision is required to prevent harm due to cognitive impairments and explain

XIV. Behavior Check if item interferes with functioning and describe below

	Sources		Source
a. ☐ Disoriented to person		m. ☐ Verbally abusive or aggressive	
b. ☐ Disoriented to place		n. ☐ Physically abusive or aggressive	
c. ☐ Disoriented to time		o. ☐ Wanders – mentally	
d. ☐ Confusion		p. ☐ Wanders – physically	
e. ☐ Withdrawn, isolates self		q. ☐ Forgetfulness	
r. ☐ Hyperactive		1. ☐ Short Term 2. ☐ Long Term	
s. ☐ Mood swings		r. ☐ Agitation	
t. ☐ Inappropriate fears, suspicions		s. ☐ Smokes carelessly	
u. ☐ Abusive to self		t. ☐ Has difficulty concentrating	
v. ☐ Drug/Alcohol abuse		u. ☐ Has difficulty sleeping	
w. ☐ Exhibits bizarre behavior		v. ☐ Cannot make own decisions	
x. ☐ Neglect to self		w. ☐ Other	

COMMENTS: Describe behavior(s) and level of supervision needed to prevent harm

☐ Additional Information attached on trailer sheet

Client	Date

XV. SYSTEMS REVIEW

Condition: Check if condition is unstable and explain. Check if medical complications are present and explain. Check if no abnormalities are reported. INTERVENTIONS: Describe all medical interventions/treatments including tasks performed by licensed professionals, and frequency of those tasks. SOURCES OF INFORMATION *(Check)*

☐ Physician ☐ Medical Record ☐ Client ☐ Caregiver ☐ Authorized Representative

A) EYES, EARS, MOUTH, AND THROAT Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Complications

Explanation:
Interventions: Description:

Performed by *(check and list frequency)*: ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

B) NEUROLOGICAL Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Complications

Explanation:
Interventions: Description:

Performed by *(check and list frequency):* ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

C) PULMONARY Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Complications

Explanation:
Interventions: Description:

Performed by *(check and list frequency):* ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

D) CARDIOVASCULAR AND CIRCULATORY Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Complications

Explanation:
Interventions: Description:

Performed by *(check and list frequency):* ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

E) MUSCULOSKELETAL Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Complications

Explanation:
Interventions: Description:

Performed by *(check and list frequency):* ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

F) GASTROINTESTINAL Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Complications

Explanation:
Interventions: Description:

Performed by *(check and list frequency):* ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

G) GENITOURINARY Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Complications

Explanation:
Interventions: Description:

Performed by *(check and list frequency):* ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

H) SKIN Condition: ☐ No abnormalities ☐ Unstable ☐ Medical Complications

Explanation:
Interventions: Description:

Performed by *(check and list frequency):* ☐ RN ☐ PT ☐ ST ☐ OT ☐ Other *(specify)*

☐ Additional Information attached on trailer sheet

Client	Date

XVI. DEVELOPMENTAL DISABILITIES *(Complete only for a client requesting an ICF-IID/DD LOC)*

☐ **PSYCHOLOGICAL EVALUATION ATTACHED**

"Persons with related conditions" is defined as persons who have severe, chronic disabilities that meets all of the following conditions 1. The disability is attributed to: ☐ Yes ☐ No a. Cerebral palsy b. Epilepsy or, c. Any other condition, other than mental illness, found to be closely related to developmental disability because this results in impairment of general intellectual functioning or adaptive behavior similar to that of developmentally disabled persons, and requires treatment or services.	2. Was manifested before the person reached age 22 ☐ Yes ☐ No 3. Is likely to continue indefinitely ☐ Yes ☐ No 4. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: a. Self-care ☐ Yes ☐ No b. Understanding ☐ Yes ☐ No c. Learning ☐ Yes ☐ No d. Mobility ☐ Yes ☐ No e. Self-direction ☐ Yes ☐ No f. Capacity for independent living ☐ Yes ☐ No

ADDITIONAL COMMENTS/SUMMARIES LEVEL OF CARE TRAILER SHEET

Indicate Section	Comments/Summary
Section	
Section	
Section	
Section	
Section	
Section	
Section	
Section	

ADDITIONAL MEDICATION PROFILE

A) Medications	RX	OTC	Dosage/ Frequency	Route	Medications *(continued)*	RX	OTC	Dosage/ Frequency	Route
11)	☐	☐			16)	☐	☐		
12)	☐	☐			17)	☐	☐		
13)	☐	☐			18)	☐	☐		
14)	☐	☐			19)	☐	☐		
15)	☐	☐			20)	☐	☐		

☐ Additional Information attached on trailer sheet

INSTRUCTIONS FOR COMPLETEING
ODM 03697 LEVEL OF CARE ASSESSMENT

GENERAL INSTRUCTION: Complete entire form by providing requested information or by indicating N/A

PAGE 1

SECTION I – DEMOGRAPHICS: Complete as indicated. For I-1, list either anticipated Medicaid vendor payment effective date for NF resident converting to Medicaid from other payment source, or list N/A.

SECTION II – REASON FOR REQUESTS: Place check mark next to only one letter and complete as indicated.

SECTION III – LOC ASSESSMENT SUMMARY: Complete as indicated after remainder of form is completed; summary must be supported by documentation on pages 2-5.

SECTION IV – INFORMAL SUPPORT: Complete as indicated.

SECTION V – LOC RECOMMENDATION: PAA Staff to complete recommendation after Section III, LOC Assessment Summary is completed;
LOC recommendation must be supported by Section III. PAA staff completing recommendation must sign recommendation, document client's choice of service settings, ensure client's or authorized representative's signature has been obtained, and obtain certification.

PAGE 2

SECTION VI – PHYSICIANS: Complete as indicated.

SECTION VII – DIAGNOSES: Place check mark(s) next to source(s) of information and complete as indicated.

SECTION VIII – HEALTH HISTORY: Place check mark(s) next to source(s) of information and complete as indicated. Indicate applicant's prognosis and rehabilitation potential.

SECTION IX – ALLERGIES: Complete as indicated.

SECTION X – MEDICATION PROFILE: Place check mark(s) next to source(s) of information and complete as indicated.

NOTE: *Check box at bottom of Page two (2) if additional information related to Page two (2) is included on the trailer sheet or if additional information related to Page two (2) is attached to the ODM 03697.*

PAGE 3

SECTION XI – ADLS, XII – IADLS AND

XIII – MEDICATION ADMINISTRATION: Place check mark(s) next to type of help needed by applicant to complete each activity. *Note:* Person submitting form must ensure all activities are completed, do not skip any activities. Refer to Ohio Administrative Code rules 5160-3-05, 06, and 08 for definitions of supervision, assistance, and ADLS. List sources of information for each activity using the code, as indicated.

In space provided, list activity*(ies)* for which applicant requires 24-hour supervision to prevent harm due to cognitive impairment(s). Description must be supported by Section VII, diagnoses.

SECTION XIV – BEHAVIOR: Place check mark(s) next to behaviors that interfere with functioning. List sources of information for each activity using the code, as indicated. In space provided, describe behavior and amount of supervision needed to prevent harm to applicant *(e.g. needs supervision while awake; needs 24-hour supervision, etc.)*

NOTE: *Check box at bottom of Page three (3) if additional information related to Page three (3) is included on the trailer sheet or if additional information related to Page three (3) is attached to the ODM 03697.*

PAGE 4

SECTION XV – SYSTEMS REVIEW: Complete as indicated.

SECTION XVI –DEVELOPMENTAL DISABILITIES: Complete as indicated.

NOTE: *Check box at bottom of Page two (2) if additional information related to Page two (2) is included on the trailer sheet or if additional information related to Page two (2) is attached to the ODM 03697.*

ADDITIONAL COMMENTS/SUMMARIES: Use for additional comment/summary by indicating section number and continuing narrative description. Also use to reference attached medical record copies by indicating section number and the phrase "see attached".

ADDITIONAL MEDICATION PROFILE: Use if space provided on Page two (2) in Section X, Medication Profile, is insufficient.

To help you understand this notice, language assistance, interpretation services, and auxiliary aids and services are available upon request at no cost to you. Services available include, but are not limited to: oral translation, written translation, and auxiliary aids. You can request these services and/or auxiliary aids by calling County Shared Services at the toll-free phone number 1-844-640-6446; individuals with a hearing impairment may call TDD 7-1-1.

Spanish

Para ayudarle a comprender este aviso, se encuentran disponibles a pedido asistencia lingüística, servicios de interpretación, ayudas auxiliares y otros servicios sin costo alguno. Los servicios disponibles incluyen, entre otros: traducción oral, traducción escrita y ayudas auxiliares. Puede solicitar estos servicios o ayudas auxiliares llamando a la Línea directa para el consumidor del Departamento de Medicaid de Ohio al 1-800-324-8680; las personas con discapacidad auditiva pueden llamar al TDD 7-1-1.

Nepali

यो सूचना बुझ्न सहायता गर्न, भाषा सहायता, व्याख्या सेवा, र सहायक उपकरण तथा सेवा तपाईंको अनुरोधमा निःशुल्क रूपमा उपलब्ध छन्। उपलब्ध सेवाहरूमा मौखिक अनुवाद, लिखित अनुवाद, र सहायक उपकरणहरू समावेश छन्, तर यिनीसँग मात्र सीमित छैन। तपाईंले यी सेवाहरू र/वा सहायक सहायताहरू अनुरोध गर्न सक्नुहुन्छ; Medicaid Consumer Hotline 1-800-324-8680; मा कल गरेर; श्रवणशक्ति कमजोर भएका व्यक्तिहरूले TDD 7-1-1 मा कल गर्न सक्छन्।

Arabic

لمساعدتك في فهم هذا الإخطار، تتوفر خدمات المساعدة اللغوية وخدمات الترجمة الفورية والمساعدات الإضافية عند الطلب دون أي تكلفة. تشمل الخدمات المتاحة، على سبيل المثال لا الحصر: الترجمة الشفوية والترجمة التحريرية والمساعدات الإضافية. يمكنك طلب هذه الخدمات أو المساعدات الإضافية أو كلتيهما عن طريق الاتصال بالخط الساخن للمستهلكين التابع لـ Medicaid على الرقم التالي 1-800-324-8680؛ وبوسع الأفراد الذين يعانون من ضعف السمع الاتصال بخدمة الهاتف النصي على الرقم التالي 1-1-7.

Haitian French Creole
Pou ede w konprann avi sa a, gen asistans lengwistik, sèvis entèpretasyon, èd oksilyè ak sèvis ki disponib gratis, lè ou fè demann pou sa. Sèvis ki disponib yo gen ladan yo, men se pa sa sèlman: tradiksyon oral, tradiksyon alekri ak èd oksilyè. Ou kapab mande sèvis sa yo ak/oswa èd oksilyè lè w rele Liy Asistans pou Konsomatè Medicaid la nan 1-800-324-8680; moun ki gen pwoblèm tande yo ka rele TDD 7-1-1.

Somali
Si lagaaga caawiyo inaad fahanto ogaysiiskan, kaalmada luqadda, adeegyada tarjumaada, iyo kaalmooyinka iyo adeegyada ayaa la heli karaa marka la codsado lacag la'aan adiga. Adeegyada la heli karo waxaa ka mid ah, laakiin aan ku xaddidnayn: tarjumaada afka, turjumaadda qoran, iyo qalabyada caawinta. Waxaad codsan kartaa adeegyadan iyo/ama caawimada caawimada adiga oo wacaya markaas Khadka Tooska ah ee Macmiilka Medicaid 1-800-324-8680; Shakhsiyaadka maqalka liidata waxay wici karaan TDD 7-1-1.

Ukrainian
Щоб допомогти вам зрозуміти зміст цього повідомлення, за запитом ви можете отримати безоплатну мовну допомогу, послуги усного перекладу, а також допоміжне обладнання та додаткові послуги. Доступні послуги включають, зокрема, усний переклад, письмовий переклад і допоміжне обладнання. Ви можете замовити ці послуги та/або допоміжне обладнання, зателефонувавши на гарячу лінію клієнтів Medicaid за номером 1-800-324-8680; для людей із вадами слуху працює номер TDD 7-1-1.

Russian
Чтобы помочь вам понять смысл этого уведомления, по запросу вы можете получить бесплатную языковую помощь, услуги устного перевода, а также вспомогательное оборудование и дополнительные услуги. Доступные услуги включают, в частности, устный перевод, письменный перевод и вспомогательное оборудование. Вы можете запросить эти услуги и/или вспомогательное оборудование, позвонив на горячую линию клиентов Medicaid по номеру 1-800-324-8680; для людей с нарушениями слуха предусмотрен номер TDD 7-1-1.

Swahili
Ili kukusaidia kuelewa notisi hii, usaidizi wa lugha, huduma za ukalimani, na visaidizi na huduma za ziada zinapatikana unapoomba bila gharama kwako. Huduma zinazopatikana ni pamoja na, lakini sio tu: tafsiri ya mdomo, tafsiri ya maandishi, na visaidizi vya ziada. Unaweza kuomba huduma hizi na/au visaidizi kwa kupiga simu ya Medicaid Consumer Hotline 1-800-324-8680; watu walio na ulemavu wa kusikia wanaweza kupiga simu TDD 7-1-1.

Kinyarwanda
Kugira ngo tugufashe gusobanukirwa iri tangazo, ubufasha bujyanye n'indimi, serivisi z'ubusemuzi, n'ibikoresho na servisi bifasha abafite ubumuga mu kumva biraboneka nta kiguzi utanze iyo ubisabye. Serivisi ziboneka zikubiyemo, ariko si gusa: ubusemuzi mu mvugo, ubusemuzi mu nyandiko, n'ibikoresho bifasha abafite ubumuga mu kumva. Ushobora gusaba izi serivisi na/cyangwa ibikoresho bifasha abafite ubumuga mu kumva binyuze mu guhamagara Umurongo utishyurwa ufasha Abakiriya ba Medicaid 1-800-324-8680; abantu bafite ibibazo mu kumva bashobora guhamagara TDD 7-1-1.

French
Pour vous aider à comprendre cet avis, une assistance linguistique, des services d'interprétation et des aides et services auxiliaires sont disponibles sur demande et sans frais. Les services disponibles comprennent, sans toutefois s’y limiter, la traduction orale, la traduction écrite et les aides auxiliaires. Vous pouvez demander ces services et/ou des aides auxiliaires en appelant la Medicaid Consumer Hotline 1-800-324-8680 ; les personnes malentendantes peuvent appeler TDD 7-1-1.

Pashtu
ستاسو په دې خبرتیا د ښه درک کولو (پوهیدو) لپاره، د ژبې مرستې، د شفاهي ژباړې خدمتونه، او اضافي مرستندویه وسایل او خدمتونه ستاسو د غوښتنې پر بنسټ پې لګښته شتون لري. په شته خدماتو کې شفاهي ژباړه، په لیکلې بڼه ژباړه، او مرستندویه وسایل شامل دي، خو یوازې په دې پورې محدود نه دي. تاسو کولی شئ د دې خدماتو او/یا مرستندویه وسایلو غوښتنه د میډیکیډ (Medicaid) د پیرودونکو ځانګړې د تلیفون شمېرې 1-800-324-8680 ته زنګ وهلو له لارې وکړئ؛ هغه کسان چې د اوربدلو کمزورتیا لري کولی شي 1-1-7 TDD ته زنګ ووهي.

Dari

برای کمک به شما در درک این اطلاعیه، کمک های زبانی، خدمات ترجمه شفاهی و کمک ها و خدمات اضافی بر اساس درخواست شما بطور رایگان برای شما ارائه می گردد. خدمات موجود شامل موارد ذیل میباشد، اما محدود به آنها نیست: ترجمه شفاهی، ترجمه کتبی و وسایل کمکی. شما می‌توانید این خدمات و/یا وسایل کمکی را با تماس با خط ویژه مصرف کنندگان Medicaid از طریق شماره 1-800-324-8680 درخواست دهید؛ افراد دارای اختلال شنوایی می‌توانند با شماره 1-1-7 TDD تماس بگیرند.

Uzbek

Bu bildirishnomani tushunishingizga yordam berish uchun so‘rovingiz asosida bepul til yordamchi xizmatlari, og‘zaki tarjima xizmatlari va qo‘shimcha yordamchi vositalar taqdim etiladi. Mavjud xizmatlar qatoriga og‘zaki tarjima, yozma tarjima hamda yordamchi vositalar kiradi. Siz ushbu xizmatlar va/yoki qo‘shimcha yordamlar haqida Medicaid mijozlari uchun mo‘ljallangan 1-800-324-8680 telefon raqamiga qo‘ng‘iroq qilib so‘rashingiz mumkin; Eshitish qobiliyati cheklangan shaxslar TDD 7-1-1 raqami orqali bog‘lanishlari mumkin.

Vietnamese

Để giúp bạn hiểu thông báo này, hỗ trợ ngôn ngữ, dịch vụ phiên dịch, phương tiện trợ giúp và dịch vụ phụ trợ được cung cấp miễn phí theo yêu cầu. Các dịch vụ có sẵn bao gồm, nhưng không giới hạn ở: dịch bằng lời nói, dịch bằng văn bản và phương tiện phụ trợ. Bạn có thể yêu cầu các dịch vụ này và/hoặc phương tiện phụ trợ bằng cách gọi tớiĐường dây nóng cho Người tiêu dùng Medicaid theo số 1-800-324-8680; người khiếm thính có thể gọi TDD 7-1-1.

Tigrinya

ነዚ ምልክታ ክትርደእዎ ንኽሕግዘኩም፣ ሓገዝ ቋንቋ፣ ኣገልግሎታት ትርጉም፣ ከምኡ'ውን ተወሰኽቲ ሓገዛትን ኣገልግሎታትን ኣብ ዝሓተትክምዎ ብዘይ ክፍሊት ይርከቡ። ዘለው ኣገልግሎታት፣ ናይ ዘረባ ትርጉም፣ ናይ ጽሑፍ ትርጉምን ተወሰኽቲ ሓገዛትን ዘጠቓልሉ ኮይኖም፣ በዚ ጥራሕ ዝድረቱ ኣይኮኑን። ናብ መስመር ቴሌፎን ተጠቀምቲ ሜዲኬይድ (Medicaid Consumer Hotline) 1-800-324-8680 ብምድዋል፣ ነዞም ኣገልግሎታትን/ወይ ተወሰኽቲ ሓገዛት ክትሓቱ ትኽእሉ ኢኹም፤ ናይ ምስማዕ ጸገም ዘለዎም ውልቀ-ሰባት ናብ TDD 7-1-1 ክድውሉ ይኽእሉ እዮም።