



2027 INDEPENDENT HEALTH'S ASSURE ADVANTAGE® HMO C-SNP ENROLLMENT APPLICATION

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit [Medicare.gov](https://www.Medicare.gov) to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.

- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
Independent Health
Attn: Membership, Government Operations
P.O. Box 610
Williamsville, NY 14231-9909

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Independent Health at (716) 635-4900 or 1-800-958-4405 toll-free. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Independent Health al (716) 635-4900 o 1-800-958-4405 TTY: 711 o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Section 1 – All fields on this page are required (unless marked optional)**Select the plan you want to join:**

☐ Independent Health's Assure Advantage® HMO C-SNP H3362-040: \$15 monthly premium

FIRST name:

LAST name:

Middle Initial:

Birth date: (MM/DD/YYYY)

(/ /)

Sex:

☐ Male ☐ Female

Phone number:

()

Permanent Residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address):

City:

State:

Zip Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street address:

City:

State:

ZIP Code:

Your Medicare information:

Medicare Number:

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Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Independent Health?

☐ Yes ☐ No

Name of other coverage:

Member number for this coverage:

Group number for this coverage

This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll is based on verification that you have a qualifying, specific chronic condition.

Members of this plan must reside in Erie County and be diagnosed with a chronic heart failure condition. Please complete the attached Pre-Enrollment Qualification Assessment Tool to determine your eligibility for this plan.

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Independent Health.
- By joining this Medicare Advantage Plan, I acknowledge that Independent Health will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Independent Health coverage begins, I must get all of my medical and prescription drug benefits from Independent Health. Benefits and services provided by Independent Health and contained in my Independent Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Independent Health will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
 - 1) This person is authorized under State law to complete this enrollment, and
 - 2) Documentation of this authority is available upon request by Medicare.

Signature:

Today's date:

If you're the authorized representative, sign above and fill out these fields:

Name:

Address:

Phone number:

Relationship to enrollee:

Section 2 – All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Independent Health at (716) 250-4401 or 1-800-665-1502 if you need information in an accessible format other than what's listed above. Our office hours are October 1 – March 31: Monday – Sunday, 8 a.m. – 8 p.m.; April 1- September 30: Monday – Friday, 8 a.m.- 8 p.m. TTY users can call 711.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

Email Communications

By checking the box(es) below and providing my email address, I agree to receive those documents and notifications electronically from Independent Health.

Email Address: _____

☐ Annual Notice of Change

☐ Part C and Part D (if applicable) Explanation of Benefits

☐ Communications related to plan details, status or transactions, promotional activities, health and wellness recommendations, health education and other information

Text Messaging and Automated Phone Call Communications

By checking the box(es) below and providing my phone number, I expressly consent to receiving from Independent Health, its affiliates, and agents automated messages, including SMS/Text messages, phone calls using automated telephone dialer systems, or prerecorded voice or artificial voice messages at the number provided. Consent is not required as a condition of coverage. You may opt out of receiving these messages at any time by replying STOP to opt out of text messaging or calling Independent Health at 716-250-4401.

Mobile Phone Number: _____

I agree to receive the following from Independent Health regarding communications related to plan details, status or transactions, promotional activities, health and wellness recommendations, health education and other information.

☐ Automated Phone Calls

☐ Text Messages

Some messages may include health information that's specific to you. If you choose to receive emails and/or text messages, please know that electronic communication isn't always secure. There's a small risk that your messages could be seen or intercepted by someone else. By opting in, you understand and accept this risk. Message and data rates may apply.

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe)

- ☐ By mail each month
- ☐ Electronic Fund Transfer from your checking account each month (Please include a voided check with this application)
- ☐ Enroll in paperless billing
- ☐ Credit card each month

You can also choose to pay your premium by having it automatically taken out of your

- ☐ Social Security Check each month or;
- ☐ Railroad Retirement Board (RRB) benefit each month

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.) If you enrolled in the EPIC fee plan, we recommend not selecting Social Security Deduction or EFT.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Independent Health the Part D-IRMAA.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____
Signature: _____ National Producer Number (Agents/Brokers only): _____

OFFICE USE ONLY Name of staff member/agent/broker (if assisted in enrollment): _____
Effective Date of Coverage: _____ Location: _____
Plan ID #: _____ ICEP/IEP: _____ AEP: _____ SEP (type): _____ OEP: _____ OSD: _____

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and have new options available to me. I moved on *(insert date)* _____.
- ☐ I recently was released from incarceration. I was released on *(insert date)* _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on *(insert date)* _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on *(insert date)* _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on *(insert date)* _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on *(insert date)* _____.
- ☐ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on *(insert date)* _____.
- ☐ I recently left a PACE program on *(insert date)* _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on *(insert date)* _____.
- ☐ I am leaving employer or union coverage on *(insert date)* _____.
- ☐ I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on *(insert date)* _____.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on *(insert date)* _____.
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity). One of the other statements here applied to me, but I was unable to make my enrollment request because of the natural disaster.

If none of these statements apply to you or you are not sure, please contact Independent Health to see if you are eligible to enroll: **(716) 635-4900** or **1-800-958-4405** (TTY users should call 711), October 1 – March 31: Monday – Sunday, 8 a.m. – 8 p.m.; April 1 – September 30: Monday – Friday, 8 a.m. – 8 p.m.

Independent Health is a Medicare Advantage organization with a Medicare contract offering HMO, HMO-SNP, HMO-POS and PPO plans. Enrollment in Independent Health depends on contract renewal.



H3362_C00867_M

Pre-Enrollment Qualification Assessment Tool

Independent Health's Assure Advantage (HMO C-SNP) is a Medicare Advantage Special Needs Plan (SNP) designed for people currently diagnosed with a chronic heart failure condition category. To enroll in this plan, a provider must have diagnosed you with this health condition.

IMPORTANT - Please complete this form and submit this form with your enrollment application

If you can answer "Yes" or "Not sure" to any of the following questions, you may be eligible to join our chronic condition SNP. When this form is completed and submitted along with an enrollment application, you will be enrolled into Independent Health's Assure Advantage (HMO C-SNP). We will attempt to verify your chronic condition with your provider during the first month of enrollment. If we are unable to verify your chronic condition, we are required to disenroll you from the Special Needs Plan.

Enrollee Information

Last Name:	First Name:	Middle Initial:
Medicare ID Number:	Phone (xxx-xxx-xxxx):	
Birth Date (MM/DD/YYYY):		

Chronic Condition Questions

1. Have you been diagnosed with chronic (or congestive) heart failure (CHF) or a related condition (see page 3)? ☐ Yes ☐ No ☐ Not Sure
2. Have you had problems with fluid retention in your lungs or swelling in your legs due to a heart problem? ☐ Yes ☐ No ☐ Not Sure
3. Do you take medication to prevent fluid retention? ☐ Yes ☐ No ☐ Not Sure

Provider Verification Form

Release of Information. By joining Independent Health's Assure Advantage (HMO C-SNP), a Medicare Advantage Special Needs Plan for chronically ill Medicare beneficiaries, I acknowledge that I have the chronic condition listed below. I authorize and direct the provider/provider representatives listed below to confirm my chronic condition if so requested by the health plan and to disclose my medical records to the health plan. The authorization shall be effective until I am no longer enrolled in the health plan. I understand that the health plan may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I do, however, understand that enrollment is contingent upon confirmation of my chronic condition by my provider's (or provider's representative) signature below. I further understand that I may revoke this authorization at any time in a signed, written communication, although the health plan may continue to maintain information obtained while this authorization was effective. Any disclosure made pursuant to this authorization that is redisclosed by the health plan is then no longer subject to the protections of the HIPAA Privacy Rule. I also acknowledge that the health plan may use, disclose, or obtain my personal health information with Medicare, any provider involved in my health care, or any other health plan as is necessary for treatment, payment and other health care operations.

ENROLLEE AUTHORIZATION: Please sign, complete and identify at least one provider who can confirm your current diagnosis of chronic heart failure:

1. Enrollee Name: _____
First Middle Last

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ DOB: _____

2. **Provider Name:** _____ **Phone:** _____

Address (if available):

**Enrollee/Authorized Legal**

Representative Signature: _____ **Date:** _____

PROVIDER/PROVIDER REPRESENTATIVE, please complete and return this form to Independent Health within 48 hours of receipt. This section must be completed in full to process the application.

I, _____ (PROVIDER/PROVIDER REPRESENTATIVE), hereby certify that
 _____ (Prospective Member) has the following health condition(s):
has a Chronic Heart Failure Condition Category (See the back of this pamphlet for a list of ICD-10 codes)

Provider/Provider Representative Signature:

Date:

For Office Use Only

Telephonic Attestation completed by:	CSNP		
	Full Name	Department	Job Title

Telephonic Attestation: Date: Time:

Representative signature: _____ Date: _____

Provider mail this form to: Independent Health
PO Box 610
Williamsville, NY 14231

Fax this form to: 716-631-8857

If you have any questions about this form, please call 1-800-958-4405 (TTY: 711) between October 1 - March 31: Monday - Sunday, 8 a.m. to 8 p.m. April 1 - September 30: Monday - Friday, 8 a.m. to 8 p.m.

Enrollment in Independent Health's Assure Advantage® (HMO C-SNP) requires a diagnosis of a Chronic Heart Failure condition. Patients may qualify for enrollment if currently diagnosed with the following ICD-10 codes. Due to the progressive nature of CHF, chronic disease management is required. Members who have early stage CHF (even if asymptomatic) also qualify for enrollment in Independent Health's Assure Advantage® (HMO C-SNP).

Diagnosis Code	Description Specific enrollment criteria includes having at least one diagnosis from the Chronic Heart Failure condition category (diagnoses listed below)
A3681	Diphtheritic cardiomyopathy
B3324	Viral cardiomyopathy
I0981	Rheumatic heart failure
I110	Hypertensive heart disease with heart failure
I130	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I132	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease
I2601	Septic pulmonary embolism with acute cor pulmonale
I2602	Saddle embolus of pulmonary artery with acute cor pulmonale
I2609	Other pulmonary embolism with acute cor pulmonale
I25.5	Ischemic cardiomyopathy
I27.xx	Pulmonary heart conditions
I28.x	Pulmonary vessel diseases
I42.x	Cardiomyopathies
I43	Cardiomyopathy in diseases classified elsewhere
I50.xx	Heart failure
I514	Myocarditis, unspecified
I515	Myocardial degeneration

Note: Please look for 3 digit prefix with either 4th (or 5th) digit qualifier in place of "x."





Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-665-1502 (TTY: 711) or speak to your provider.

Español (Spanish): ATENCIÓN: Si habla español, hay servicios de asistencia lingüística disponibles para usted de forma gratuita. También están disponibles, sin cargo adicional, los auxilios y servicios apropiados para proporcionar información en formatos accesibles. Llame al 1-800-665-1502 (TTY: 711) o hable con su proveedor.

中文 (Simplified Chinese): 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-665-1502（文本电话：711）或咨询您的服务提供商。

台語 (Traditional Chinese): 注意：如果您說[台語]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-665-1502（TTY：711）或與您的提供者討論。

РУССКИЙ (Russian): ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-665-1502 (TTY: 711) или обратитесь к своему поставщику услуг.

יידיש (Yiddish): באטייט: אויב איר רעדט יידיש, שפראך הילף סערוויסעס זענען בארעכטיגט פאר דיר פריי. צונעמען אידס און באדינונגס פֿאר פראוויידינג אינפֿארמאציע אין צוטריטלעך פֿארמאטירונגען זענען אויך בנימצא פריי. רופן 1-800-665-1502 (TTY: 711) אָדער רעדן מיט דיין טרעגער.

বাংলা (Bengali): মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-800-665-1502 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

Kreyòl Avisyen (Haitian Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòm aksesib yo disponib gratis tou. Rele nan 1-800-665-1502 (TTY: 711) oswa pale avèk founisè w la.

한국어 (Korean): 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-665-1502 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

(Arabic) العربية: تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-665-1502 (711) أو تحدث إلى مقدم الخدمة.

Italiano (Italian): ATTENZIONE: Se parli italiano, sono disponibili servizi di assistenza linguistica gratuiti per te. Sono disponibili gratuitamente anche ausili e servizi appropriati per fornire informazioni in formati accessibili. Chiama il 1-800-665-1502 (TTY: 711) o parla con il tuo fornitore.

Français (French): ATTENTION: Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-665-1502 (TTY: 711) ou parlez à votre prestataire.

POLSKI (Polish): UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-665-1502 (TTY: 711) lub porozmawiaj ze swoim dostawcą.

(Urdu) اردو: توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 1-800-665-1502 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

SHQIP (Albanian): VINI RE: Nëse flisni [shqip], shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndhima të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 1-800-665-1502 (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.

ਪੰਜਾਬੀ (Punjabi): ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੁਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 1-800-665-1502 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।