

# Community Health Coverage Program (CHCP) Application for subsidy – 2026

Use this form to apply for a subsidy to pay your monthly premiums and most out-of-pocket costs under the KP HI Standard Platinum 0/10 plan. There is no cost to apply.

Enrollment in CHCP is available during the Individuals and Families annual open enrollment and special enrollment periods. The special enrollment period generally lasts 60 calendar days from the date of your qualifying life event. Some qualifying life events allow more than 60 calendar days from the date of your qualifying life event. Visit [kp.org/chcspecialenrollment](https://kp.org/chcspecialenrollment) for more information. To apply, follow these steps:

## Step 1: Fill out the Application for subsidy form

- Type or print using black or blue ink.
- Answer all required questions completely.
- Sign the form.
- Make a copy of the completed form for your records.

## Step 2: Fill out the separate Kaiser Permanente Application for health coverage.

## Step 3: Include proof of income

Attach copies of the most current proof of your household's gross income:

- If employer paid – include your last 2 paycheck stubs, W-2, or 1040 tax form from previous year. Please note: if tax form is submitted, no other proof of income is required.
- If self-employed – include Schedule C and page 1 (the adjusted gross income page) of last year's federal income tax return or a profit and loss form.
- If paid in cash – include a signed letter indicating gross income and pay frequency from your employer.
- See Section 4 for more examples of proof of income.

If your household has income deductions, provide proof such as:

- Student loan interest – include your last student loan statement.
- Self-employed – Schedule C and page 1 (the adjusted gross income page) of last year's federal income tax return or a profit and loss form.

## Eligibility rules:

Eligibility for CHCP will be considered for individuals who are uninsured and:

- Live in the Kaiser Foundation Health Plan, Inc. service area on Oahu and Maui.
- Live in a household with income up to 300% of the Federal Poverty Level.
- Not eligible for other public or private health coverage such as, but not limited to, QUEST (Medicaid), Medicare, an affordable job-based health plan, or financial help through the health benefit exchange.
- In most cases, child dependents must be younger than 26.
- Individuals over 21 are eligible to receive the CHCP subsidy for a maximum of 3 years in a row. Eligible dependents can continue to receive the subsidy until they turn 21, no matter how long they've been in the program.
- The CHCP subsidy is available as a one-time resource, and all members must reapply annually. Members who do not reapply in consecutive years will lose future eligibility.

#### **Step 4: Include additional documents**

- QUEST (Medicaid) and/or health benefit exchange denial letters if applicable.
- Provide proof of guardianship if applicable.
- Other information or documentation that may help us evaluate your eligibility.

#### **Step 5: Send your forms, proof of income, and all other required documents**

Send your completed and signed Application for subsidy, Application for health coverage, proof of current income, income deductions, and other required documents through one of the following options:

- By email (preferred):  
**CHC-Applications@kp.org**  
(Include "application" in the subject line)
- By mail:  
Kaiser Permanente  
Attn: CHC  
P.O. Box 939095  
San Diego, CA 92193-9095
- By fax:  
**1-855-355-5334**

#### **We're here to help:**

If you have questions about the Kaiser Permanente Community Health Coverage Program (CHCP) or about this form, please call us at:

**1-800-966-5955 (TTY 711)**

Monday through Friday,  
8 a.m. to 5 p.m. and  
Saturday, 8 a.m. to 12 p.m.  
Hawaii time  
(closed major holidays)

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**Please note:** Continued eligibility for CHCP isn't guaranteed. We reserve the right to close enrollment or change the eligibility rules at any time. If you're approved for the subsidy, the subsidy period is limited and we'll contact you in the future to confirm that you still qualify.

Kaiser Permanente will keep your information private, as required by law, and use your personal information only to see if you qualify for Kaiser Permanente's subsidy.

If you apply for a Kaiser Permanente subsidy through a community organization, that organization may use your information to determine your eligibility for another health care or social service program, or for other purposes required by law.

# Frequently asked questions

## 1. How long does it take to find out if I am approved or denied for the Kaiser Permanente Community Health Coverage Program (CHCP)?

Completed forms that include all required documentation can take up to 6 weeks to process. If information is missing, it may take longer and you may miss the deadline for applying. Completion of this form does not guarantee enrollment in CHCP.

## 2. How much will I pay each month for CHCP?

No monthly payment is required. Kaiser Permanente will subsidize the full monthly premium.

## 3. What happens when I no longer meet the eligibility requirements?

When you no longer meet our eligibility requirements, you will be disenrolled from CHCP. You will remain enrolled in the KP HI Standard Platinum 0/10 plan, **but you'll have to pay your full monthly premiums and out-of-pocket costs**, unless you ask us to end your membership or until you fail to pay the full premium.

## 4. I can't afford to pay for coverage through the health benefit exchange. Can I still qualify for CHCP?

Not being able to pay health benefit exchange premiums does not qualify you for CHCP. You must meet the CHCP income and other criteria to qualify.

## 5. Do I qualify for CHCP if I am offered health coverage through an employer?

To be eligible for CHCP, applicants must not have access to an employer plan that is considered affordable. CHCP follows federal guidelines for affordability. For 2025, the threshold that determines if an employer plan is affordable is if the premium is equal to or less than 9.02% of one's household income. If you believe your job-based coverage is unaffordable, please submit proof of job-based coverage and include information on the cost of coverage and frequency of payment.

## 6. What other health coverage programs are available?

**Find out if you qualify for QUEST (Medicaid).** This option may be available to applicants born in the United States or lawful permanent residents who meet the following eligibility requirements:

- Children younger than 19 living with households with income up to 313% of the Federal Poverty Level (\$56,309 for an individual or \$115,747 for a family of 4 in 2025).
- Adults 19 or older with household income up to 138% of the FPL (\$24,826 for an individual or \$51,032 for a family of 4 in 2025) Kaiser Permanente is a QUEST (Medicaid) provider and may be available to you.
- Pregnant individuals with income up to 196% of FPL (\$35,260 for an individual or \$72,481 for a family of 4 in 2025).
- Seniors and people with disabilities with limited household income may also qualify.
- For more information please visit [kp.org/Medicaid/hi](https://kp.org/Medicaid/hi).

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**Buy health care coverage through the health benefit exchange.** If you qualify, you may get help paying for your plan premiums or out-of-pocket costs. Remember to enroll during the health benefit exchange open enrollment period. If you wait until after the open enrollment period ends, you'll need a qualifying life event to enroll in a new plan. For more information, visit: **buykp.org**.

**Call us at 1-800-488-3590 (TTY 711) or visit buykp.org** to learn about other Kaiser Permanente for Individuals and Families plan choices.

**Find out if you qualify for Medicare,** a federal program available to people ages 65 or older. There are different periods in which you may be eligible to enroll in a Medicare health plan. Visit **kp.org/medicare** for more information. If you have limited household income, you may qualify for QUEST (Medicaid). Please visit **kp.org/medicaid/hi** to learn more.

### **7. What if I'm not accepted into CHCP?**

If you're not accepted, there may be other health coverage programs available to you. See question 6 for more information.

## SECTION 1: Applicant information (Required)

### Primary applicant

The person who will be covered by the health plan and applying for the Kaiser Permanente Community Health Coverage Program (CHCP) subsidy. If applying for a child under 18, complete section 1 with the child's information and also complete section 2 with the parent or legal guardian information.

First name\*

MI

Last name\*

Date of birth\* (mm/dd/yyyy)

Medical record number (if available)

Gender\*

Male  Female  Undeclared

Home phone

Mobile phone

Home address\* (Include Apt. Number. No P. O. boxes, please)

City\*

State\*

ZIP code\*

Mailing address (If different than home address. Include apt. number.)

City

State

ZIP code

Email

Please answer **ALL** applicable questions below about the primary applicant. This information is only used to find out if the primary applicant is eligible for CHCP or other programs that provide health coverage.

Is the primary applicant...

**Offered health coverage through an employer?\***

Yes  No

**Not eligible for (or has received a denial of coverage from) public health programs or other subsidized insurance options?\*** (for example: Medicaid or Medicare)

Yes  No

\*Indicates a required field

## SECTION 2: Parent or legal guardian (if applicable)

Only complete this section if you are the parent or legal guardian of the minor (child under 18) listed in section 1.

First name	<input type="text"/>	MI	<input type="text"/>
Last name	<input type="text"/>	Date of birth (mm/dd/yyyy)	<input type="text"/> / <input type="text"/> / <input type="text"/>
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undeclared	Home phone	<input type="text"/> - <input type="text"/> - <input type="text"/>
		Mobile phone	<input type="text"/> - <input type="text"/> - <input type="text"/>
Mailing address (Include Apt. Number. P. O. boxes acceptable)	<input type="text"/>		
City	<input type="text"/>	State	<input type="text"/>
		ZIP code	<input type="text"/>
Email	<input type="text"/>		

## SECTION 3: Family information (if applicable)

### Spouse/domestic partner to be covered (if applicable)

Please complete this section for the spouse/domestic partner who will be covered by the health plan and applying for the Kaiser Permanente Community Health Coverage Program (CHCP) subsidy. Only complete this section if the primary applicant listed in section 1 is an adult and is seeking coverage for their spouse or domestic partner.

First name	<input type="text"/>	MI	<input type="text"/>	Choose one:
				<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner
Last name	<input type="text"/>	Date of birth (mm/dd/yyyy)	<input type="text"/> / <input type="text"/> / <input type="text"/>	
Medical record number (if available)	<input type="text"/>	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undeclared	

Please answer ALL applicable questions below about the spouse/domestic partner. This information is only used to find out if the spouse/domestic partner is eligible for CHCP or other programs that provide health coverage.

Is the spouse/domestic partner...

**Offered health coverage through an employer?\***

Yes  No

**Not eligible for (or has received a denial of coverage from) public health programs or other subsidized insurance options?\*** (for example: Medicaid or Medicare)

Yes  No

\*Indicates a required field

(continues)

### SECTION 3: Family information *(continued)*

#### Dependent 1 to be covered

Please complete this section for each additional dependent who will be covered by the health plan and applying for the Kaiser Permanente Community Health Coverage Program (CHCP) subsidy. Only complete this section if the primary applicant listed in section 1 is an adult and is seeking coverage for additional dependents, OR if applicant in section 1 is a minor and the parent/legal guardian (listed in section 2) has additional minors seeking coverage.

**If you have more than 3 dependents applying, please copy this page and fill out the same information requested below for each additional dependent.**

First name

MI

Last name

Date of birth (mm/dd/yyyy)

Medical record number (if available)

Gender

Male  Female  
 Undeclared

Relationship to primary applicant

Please answer **ALL** applicable questions below about the dependent. This information is only used to find out if the dependent is eligible for CHCP or other programs that provide health coverage.

Is the dependent ...

**Offered health coverage through an employer?\***

Yes  No

**Not eligible for (or has received a denial of coverage from) public health programs or other subsidized insurance options?\*** (for example: Medicaid or Medicare)

Yes  No

\*Indicates a required field

*(continues)*

### SECTION 3: Family information *(continued)*

#### Dependent 2 to be covered

Please complete this section for each additional dependent who will be covered by the health plan and applying for the Kaiser Permanente Community Health Coverage Program (CHCP) subsidy. Only complete this section if the primary applicant listed in section 1 is an adult and is seeking coverage for additional dependents, OR if applicant in section 1 is a minor and the parent/legal guardian (listed in section 2) has additional minors seeking coverage.

First name		MI	
Last name		Date of birth (mm/dd/yyyy)	
Medical record number (if available)	Gender	Relationship to primary applicant	
	<input type="checkbox"/> Male <input type="checkbox"/> Female		
	<input type="checkbox"/> Undeclared		

Please answer **ALL** applicable questions below about the dependent. This information is only used to find out if the dependent is eligible for CHCP or other programs that provide health coverage.

Is the dependent ...

**Offered health coverage through an employer?\***  Yes  No

**Not eligible for (or has received a denial of coverage from) public health programs or other subsidized insurance options?\*** (for example: Medicaid or Medicare)  Yes  No

#### Dependent 3 to be covered

Please complete this section for each additional dependent who will be covered by the health plan and applying for the CHCP subsidy. Only complete this section if the primary applicant listed in section 1 is an adult and is seeking coverage for additional dependents, OR if applicant in section 1 is a minor and the parent/legal guardian (listed in section 2) has additional minors seeking coverage.

First name		MI	
Last name		Date of birth (mm/dd/yyyy)	
Medical record number (if available)	Gender	Relationship to primary applicant	
	<input type="checkbox"/> Male <input type="checkbox"/> Female		
	<input type="checkbox"/> Undeclared		

Please answer **ALL** applicable questions below about the dependent. This information is only used to find out if the dependent is eligible for CHCP or other programs that provide health coverage.

Is the dependent ...

**Offered health coverage through an employer?\***  Yes  No

**Not eligible for (or has received a denial of coverage from) public health programs or other subsidized insurance options?\*** (for example: Medicaid or Medicare)  Yes  No

\*Indicates a required field

## SECTION 4: Household income (Required)

Your family size, household income, and proof of income documents help us determine if you qualify for CHCP. To calculate total yearly household income, we'll add up the amounts shown in your proof of income documents and subtract any deductions.

**(A) How many family members<sup>†</sup> live in your household?\*** \_\_\_\_\_

<sup>†</sup>If you file taxes, this is the same number of family members that you report on your tax form. (You do not need to file taxes to apply.) This usually includes you and the immediate family members who live with you. Like your spouse and your children 18 and younger (up to 23 if a student).

**(B) How many of the family members counted in question (A) above contribute to your household income?\*** \_\_\_\_\_

Don't include working child dependents (18 and younger, or up to 23 if a student) whose income is below the tax-filing threshold (\$14,600 in 2025). Don't submit proof of income documents for them either.

I do not work / No one in my household works. (if this is selected, skip sections C & D)

**(C) Provide proof of your household income.**

**If your household DOES NOT have proof of income (for example: a paystub or W-2), check the box below and fill in the blank with monthly household income.**

I attest that I have no proof of income. My MONTHLY household gross income is \$\_\_\_\_\_ per month.

**If you have income that varies by month, such as tips, overtime, or commissions, check the box below and fill in the blank with the estimated total gross income in 2025.**

I attest that I have income that varies by month. My total expected gross income in 2025 is \$\_\_\_\_\_.

Include the total amount received so far this year and estimate the expected amount for the rest of the year.

**If your household has proof of income, please submit documentation for the income you received. Attach copies of the most current proof of income for EVERY family member that contributes to household income.**

**Qualifying income and relevant examples are listed below:**

<b>Wages and/or tips:</b>	Your last 2 paycheck stubs, W-2 from employer, or last year's 1040 tax form. Note: if tax form is submitted, no other proof of income is required.
<b>Self-employment:</b>	A profit and loss form, or schedule C and page 1 of last year's federal income tax return (the adjusted gross income page)
<b>Social security payments:</b>	Award letters for social security and Social Security Disability Insurance (SSDI) payments
<b>Unemployment benefits</b>	Award letters for unemployment benefits
<b>Alimony received</b>	Submit court documents or a letter from your former spouse detailing payment information.(only if your divorce or separation was finalized before January 1, 2019)
<b>Student financial aid used for living expenses</b> (Student loans and financial aid for tuition/education expenses are not counted as income.)	
<b>Pension/retirement income</b>	
<b>Rental income from property you own and lease</b>	
<b>Interest or investment income and annuities</b>	
<b>Other income like capital gains, clergy earnings, or gambling income</b>	

**Please explain any special situation that we should consider when we are reviewing your income documents.**

(if applicable) \_\_\_\_\_

**(D) Attach copies of the most current proof of tax deductions for EVERY family member that contributes to household income. (if applicable)**

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## SECTION 4: Household income (Required)

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### Qualifying Deductions:

- **Self-employed expenses:** Only if submitting a profit and loss form. If submitting a schedule C of last year's federal income tax return, we will review the adjusted gross income on page 1.
  - **Alimony you pay:** Submit court documents or a letter from your former spouse detailing payment information. (only if your divorce or separation was finalized before January 1, 2019)
  - **Interest you pay on a student loan:** Submit your 1098-E Student Loan Interest form from the most recent tax year.
  - **IRA contributions:** Submit your Form 5498 from the most recent tax year. (if you don't have a retirement account through a job)
  - **Teacher expenses** (if you're a teacher and pay for supplies out-of-pocket)
  - **Health Savings Account (HSA) deposits:** Submit your completed Form 8889. (in limited situations)
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## SECTION 5: Community Partner Verification

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Organization name

Organization phone

Phone extension (if applicable)

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Organization email address

Community partner representative

I attest that I assisted the applicant(s) with this application for the Kaiser Permanente Community Health Coverage Program (CHCP). I understand and agree that I will commit to serving as a point of contact for Kaiser Permanente Membership Administration regarding follow up or questions related to this application.

X

Date (mm/dd/yyyy)

 /  / 

Signature of community partner representative

(continues)

## SECTION 6: Choose an authorized representative (if you have one)

You can give a community partner/agency, representative, relative, or trusted friend permission to talk about this form with us, see your information, or act for you on matters related to this form only. This person or community partner/agency is called an authorized representative.

First name

MI

Last name

Organization name (if applicable)

Phone

**By signing, you've appointed this person or community partner/agency as your legally authorized representative to get information for this Kaiser Permanente form and to act for you on matters related to this form.**

X

Date (mm/dd/yyyy)

Primary applicant (parent or legal guardian for children under 18)

**This authorization lasts one (1) year from your signature date or until you cancel it. You may cancel the authorization at any time by submitting a signed written request to Kaiser Permanente, Attn: CHC, P.O. Box 939095, San Diego, CA 92193-9095 or fax: 1-855-355-5334. Once you cancel, we will stop sharing your information and no longer use it, except to the extent that the information has been relied upon before. Once we disclose to your representative, your information may be redisclosed by your representative and no longer protected by federal privacy law. Even if you don't sign this authorization, we will still process your application for the Kaiser Permanente Community Health Coverage Program (CHCP) subsidy but we will not be able to share your information with your representative. You have a right to receive a copy of this authorization.**

X

Date (mm/dd/yyyy)

Primary applicant (parent or legal guardian for children under 18)

## SECTION 7: Sign the application agreement (Required)

By signing this form, you certify the information on this form is correct and accurate. If you provide incorrect or incomplete information on this form or in further correspondence concerning this form, any Kaiser Permanente subsidy to cover costs related to health coverage may be terminated. Kaiser Permanente reserves the right to request additional documentation at any time to verify our member's eligibility. Membership approval for Kaiser Permanente's Community Health Coverage Program (CHCP) is not guaranteed as it is based on eligibility and availability.

X

Date (mm/dd/yyyy)

Primary applicant (parent or legal guardian for children under 18)

In Hawaii, all plans are offered and underwritten by Kaiser Foundation Health Plan, Inc., 711 Kapiolani Blvd., Honolulu, HI 96813.

## NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan, Inc. (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

- 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, such as large print, audio, braille, and accessible electronic 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, call **1-800-966-5955** (TTY: **711**)

If you believe that Kaiser Health Plan 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 by mail or phone at:

### Membership Services

**Attn: Kaiser Civil Rights Coordinator**  
**711 Kapiolani Blvd**  
**Honolulu, HI 96813**  
**1-800-966-5955**

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, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at <https://healthy.kaiserpermanente.org/hawaii/language-assistance/nondiscrimination-notice>

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## HELP IN YOUR LANGUAGE

**ATTENTION:** If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-966-5955** (TTY: **711**).

**Cebuano (Bisaya) PAGPAHIMANGNO:** Kung nag-istorya ka og Cebuano, ang mga serbisyo sa tabang sa pinulongan lakip ang angay nga mga auxiliary nga mga himan ug serbisyo, libre, anaa kanimo. Tawag sa **1-800-966-5955** (TTY: **711**).

**中文 (Chinese) 注意事項:** 如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-966-5955** (TTY: **711**)。

**Chuuk (Chukese) ESINESIN:** Ika en mi sine Fosun Chuuk, mi kawor aninisin fosun fonu mei pachonong pisekin aninis, ese kamo, mi kawor ngonuk. Kekeru **1-800-966-5955** (TTY: **711**).

**‘Ōlelo Hawai‘i (Hawaiian) E NĀNĀ MAI:** Inā ho‘opuka ‘oe i ka ‘ōlelo Hawai‘i, hiki iā ‘oe ke nā lawelawe kōkua ‘ōlelo me nā kōkua kōkua kūpono a me nā lawelawe, manuahi ‘ole, loa‘a i ke kōkua manuahi. E kelepona i ka helu **1-800-966-5955** (TTY: **711**).

**Iloko (Ilocano) ATENSION:** No makasaoka iti Ilokano, dagiti serbisio a tulong iti pagsasao agraman dagiti maitutop a kanayonan a tulong ken serbisio, a libre, ket mabalin a mausar para kenka. Tawagan ti **1-800-966-5955** (TTY: **711**)

**日本語 (Japanese) 注意:** 日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-800-966-5955** までお電話ください (TTY: **711**)。

**한국어 (Korean) 주의:** 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-966-5955** (TTY: **711**)로 전화해 주세요.

**ລາວ (Laotian) ເອົາໃຈໃສ່:** ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອທີ່ເໝາະສົມ ຈະມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ **1-800-966-5955** (TTY: **711**).

**Kajin Majōl (Marshallese) Roñjake:** Ñe kwōjelā kajin Kajin Majōl, eo ej jipañ eok ilo kajin in ekaoba jermal ko jet, ejjelok oñāāer, repeļlok ñan eok. Kūr tok **1-800-966-5955** (TTY: **711**).

**Naabeehó (Navajo) DÍÍ BAA AKÓ NÍNÍZIN:** Díí saad bee yánítí’go Diné Bizaad, saad bee áká’ánída’áwo’déé’, biniit’aa da beeso ndinish’aah t’aala’I bí’aa ‘anashwo’ doo biniit’aa, t’aadoo baahilinigoo bits’aadoo yeel, t’áá jiik’eh, éí ná hóló, koji’ hódíílnih **1-800-966-5955** (TTY: **711**).

**Lokaiahn Pohnpei (Pohnpeian) MEHN KAIR:** Ma komw kin lokiaiahn Pohnpei, wasahn sawas en palien me kele mehleh oh sarawi kan me pahn limpoak, en kak sawa ni ke, lokaia kak sawas ni sohte isais. Koahl nempe **1-800-966-5955** (TTY: **711**).

**Faa-Samoa (Samoan) FA'AMALU:** Afai e te tautala i le Gagana Samoa, o auaunaga fesoasoani i le gagana, e aofia ai meafaigaluega talafeagai ma auaunaga, e leai ni totoi, o lo'o avanoa mo oe. Fa'amalie atu i le **1-800-966-5955** (TTY: **711**).

**Español (Spanish) ATENCIÓN:** Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-966-5955** (TTY: **711**).

**Tagalog (Tagalog) PAALALA:** Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-966-5955** (TTY: **711**).

**Lea Faka-Tonga (Tongan) FAKATOKANGA:** Kapau ‘oku ke lea Faka-Tonga, ‘oku ‘i ai ha sevesi tokoni fakatonu lea pea mo ha naunau me’a fanongo, ‘oku ta’etotongi, mo faingamalie kiate koe. Taa **1-800-966-5955** (TTY: **711**).

**Tiếng Việt (Vietnamese) CHÚ Ý:** Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-966-5955** (TTY: **711**).

