Health Risk Assessment

Please fill out all required fields. We will use your information to refer you (member) to care management programs that may help you live a healthier life.

Helpful tips – If any of the information listed is incorrect, please contact Department of Children and Families at 850-300-4323, Monday through Friday, from 7 a.m. to 6 p.m. Eastern time.

A: About You

Today's date _____

Name of person completing form _____

I am filling out this form for:

- ☐ Myself
- ☐ Child
- ☐ Friend
- ☐ Parent
- ☐ Sibling
- ☐ Spouse
- ☐ Foster child

Do you agree to receive email and/or text communications (e.g., reminders, letters, educational materials, etc.) from Humana?

- ☐ Yes
- ☐ No

Please provide cellphone number _____

Please provide email address _____

Member name _____ Member ID _____

Parent/guardian name, if applicable _____

Date of birth _____

Home phone number _____ Cellphone number _____

Emergency contact name _____

Emergency contact phone number _____

Humana
Healthy Horizons®
in Florida

What language are you most comfortable speaking?

☐ English ☐ Spanish ☐ Other ☐ I (member) choose not to answer this question

What was your (member's) sex at birth?

☐ Female
☐ Male
☐ Unavailable
☐ Decline to answer

What gender do you (member) currently identify with?

☐ Female
☐ Male
☐ Female-to-male/Transgender Male/Trans Man
☐ Male-to-Female/Transgender Female/Trans Woman
☐ Genderqueer/Non-binary, neither exclusively male or female
☐ Other
☐ Decline to answer

What are your (member's) pronouns?

☐ She/Her/Hers
☐ He/Him/His
☐ They/Them/Theirs
☐ Other
☐ Decline to answer

What is your (member's) sexual orientation?

☐ Straight or heterosexual
☐ Lesbian, gay or homosexual
☐ Bisexual
☐ Something else
☐ Don't Know
☐ Decline to answer

B: Your Medical History

Do you (member) know the name of your (or the member's) primary care physician (PCP) or obstetrician-gynecologist (OB-GYN)?

☐ Yes ☐ No

Name _____

Where do you (member) most often go for medical help?

☐ Clinic
☐ Emergency room
☐ Doctor's office
☐ Urgent care center
☐ Telehealth
☐ I (member) choose not to answer this question

Do you (member) go to other doctors or healthcare providers in addition to, or instead of, your PCP?

☐ Yes ☐ No

Member ID _____

Please tell us who you (member) see and the reason you (member) see this doctor.

Doctor's name	Reason you (member) see this doctor

How long has it been since your (member's) last checkup?

- ☐ Within the last 3 months
- ☐ Between 3 to 12 months ago
- ☐ More than 12 months ago
- ☐ I (member) have never had a regular checkup
- ☐ I (member) do not have a PCP
- ☐ I (member) have a future checkup scheduled with my PCP on _____

Would you like help to make an appointment with your (member's) PCP or OB-GYN (pregnant member)?

☐ Yes ☐ No

*If yes, please reach out to our Care Management Team **800-229-9880 (TTY: 711)** for assistance

Has a lack of transportation kept you (member) from getting to medical appointments or from getting medications?

☐ Yes ☐ No ☐ I (member) choose not to answer this question

Has a lack of transportation kept you (member) from getting to non-medical appointments, work, and/or from getting things that you (member) need?

☐ Yes ☐ No ☐ I (member) choose not to answer this question

Have you (member) had an annual dental visit in the past 12 months?

☐ Yes ☐ No

Did you (member) have a flu vaccination between August and March of this flu season?

☐ Yes ☐ No

Do you plan on receiving or have received either the COVID vaccine or booster?
(For members 6 months and older)

- ☐ Yes, already received
- ☐ Yes, planning
- ☐ No
- ☐ Unsure
- ☐ Scheduled - I (member) scheduled to receive my vaccination in the home or at a site
- ☐ Refused
  - ☐ I (member) do not feel it is needed
  - ☐ I (member) am concerned about side effects
  - ☐ I (member) was advised by provider to not receive
  - ☐ I (member) am nervous about receiving
  - ☐ I (member) do not have transportation and do not want to use the transportation benefit
  - ☐ Other

How easy is it for you (member) to get medical care when needed?

☐ Easy ☐ Somewhat difficult ☐ Very difficult ☐ Have not needed medical care

In the past 30 days, how many times have you (member) been to an emergency room (ER)?

☐ 0 ☐ 1-5 ☐ 6-10 ☐ 11-20 ☐ 21-30

In the past 12 months, how many times have you (member) had an overnight hospitalization?

☐ 0 ☐ 1-3 ☐ 4-5 ☐ 6-10 ☐ 11+

Please check Yes, No or N/A

Condition Name	Have you (member) been diagnosed with this condition?	If yes, did your (member's) doctor diagnose the condition in the last 6 months?	If yes, are you (member) currently under the care of a doctor for this condition?	If yes, do you (member) need help managing these condition(s)? A nurse Case Manager can outreach to support.
AIDS	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Asthma	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Cancer	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Chronic Kidney Disease	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Chronic Obstructive Pulmonary Disease (COPD)	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A

Member ID _____

Please check Yes, No or N/A				
Condition Name	**Have you (member) been diagnosed with this condition?**	**If yes, did your (member's) doctor diagnose the condition in the last 6 months?**	**If yes, are you (member) currently under the care of a doctor for this condition?**	**If yes, do you (member) need help managing these condition(s)? A nurse Case Manager can outreach to support.**
Cystic fibrosis	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Diabetes	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Heart Failure	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
High Blood pressure	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
HIV	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Sickle Cell Disease	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A

Family History

Condition Name	Has any immediate family member (parents, grandparents, siblings, children) been diagnosed with any of these conditions?		
AIDS	☐ Yes	☐ No	☐ N/A
Asthma	☐ Yes	☐ No	☐ N/A
Cancer	☐ Yes	☐ No	☐ N/A
Chronic Kidney Disease	☐ Yes	☐ No	☐ N/A
Chronic Obstructive Pulmonary Disease (COPD)	☐ Yes	☐ No	☐ N/A
Cystic Fibrosis	☐ Yes	☐ No	☐ N/A
Diabetes	☐ Yes	☐ No	☐ N/A
Heart Failure	☐ Yes	☐ No	☐ N/A
High Blood Pressure	☐ Yes	☐ No	☐ N/A
HIV	☐ Yes	☐ No	☐ N/A
Sickle Cell Disease	☐ Yes	☐ No	☐ N/A

C: Your Healthy Lifestyle

How tall are you? _____ feet and _____ inches

How much do you weigh? _____ pounds

How do you (member) feel about your current weight? (Select one)

- ☐ I am happy with my weight.
- ☐ I am not happy with my weight, but I am not ready to make a change.
- ☐ I would like to change my weight and would appreciate help doing so.

Nutrition

On average, how many servings of fruits and vegetables do you eat every day? (1 "serving" of fruit is 1 medium size fruit; 1 serving of vegetables is 1 cup of leafy or ½ cup fresh vegetables)

☐ 1-2 servings per day ☐ 2-4 servings per day ☐ 4+ servings per day ☐ None

On average, how many servings of dairy products do you have every day? (1 "serving" of dairy is about a slice of cheese, a cup of yogurt, or a cup of milk or dairy substitute.)

☐ 1-2 servings per day ☐ 2-4 servings per day ☐ 4+ servings per day ☐ None

Physical Activity

How many days a week do you exercise in some way (e.g., walking, bicycling, swimming, yoga, strength training, household chores, raking the yard) inside or outside the home?

☐ 1-3 days ☐ 4 or more days ☐ I (member) do not exercise

On average, how many total minutes do you spend exercising, on days when you do exercise?

☐ Less than 30 minutes ☐ Greater than 30 minutes ☐ I (member) do not exercise

How intensely do you exercise?

- ☐ Low/Light-intensity (walking at leisurely pace, beginner yoga, cooking activities, light household chores)
- ☐ Medium/Moderate-intensity (bicycling, raking the yard, swimming, strength training, walking briskly)
- ☐ High/Vigorous-intensity (jogging, running, high-impact aerobics, carrying groceries upstairs, strenuous fitness class)
- ☐ I (member) do not exercise

On average, how often do you do strength-training exercises such as squats, push-ups, pull-ups, or weight training?

☐ 1-2 days per week ☐ 3-5 days per week ☐ 6 or 7 days per week ☐ Never

How many times in the past year have you (member) had:

• 5 or more drinks in a day (males) **• 4 or more drinks in a day (females)**

One drink is 12 ounces of beer (or 1 beer), 5 ounces of wine (or a glass of wine), or 1.5 ounces of 80-proof spirits (or 1 mixed drink).

☐ Never ☐ Once or Twice ☐ Daily or almost daily ☐ Weekly

☐ Monthly ☐ N/A

Have you (member) ever felt you should cut down on your drinking?

☐ Yes ☐ No ☐ N/A

How many times in the past year have you (member) smoked, vaped, or chewed tobacco?

☐ Never ☐ Once or Twice ☐ Daily or almost daily ☐ Weekly

☐ Monthly ☐ N/A

How do you (member) feel about your (member's) current smoking habits?

☐ I (Member) already quit smoking

☐ I (Member) have no intention of stopping

☐ I (Member) plan to stop smoking in the future

☐ I (Member) would like to know how to begin to stop smoking now

☐ I (Member) have never smoked

☐ N/A

How many times in the past year have you (member) used prescription drugs for non-medical reasons?

☐ Never ☐ Once or Twice ☐ Daily or almost daily ☐ Weekly

☐ Monthly ☐ N/A

How many times in the past year have you (member) used illegal drugs?

☐ Never ☐ Once or Twice ☐ Daily or almost daily ☐ Weekly

☐ Monthly ☐ N/A

Member ID _____

Please answer the following question about any medications you take:

How many different medications do you take per day?

☐ 0 ☐ 1-5 ☐ 6-10 ☐ 11-20 ☐ More than 20

D: Your Social and Mental Wellness

Please check Yes, No or N/A				
Condition Name	**Have you (member) been diagnosed with this condition?**	**If yes, did your (member's) doctor diagnose the condition in the last 6 months?**	**If yes, are you (member) currently under the care of a doctor for this condition?**	**If yes, do you (member) need help managing these condition(s)? A nurse Case Manager can outreach to support.**
Anxiety	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Attention Deficit Hyperactivity Disorder (ADHD)	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Autism	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Bipolar	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Depression	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Eating Disorder, such as anorexia or bulimia	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Oppositional Defiant Disorder (ODD)	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Post-Traumatic Stress Disorder (PTSD)	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Schizophrenia	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A

Member ID _____

How often do you (member) see or talk to people that you (member) care about and/or to whom you (member) feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

☐ Less than once a week ☐ 1 to 2 times a week ☐ 3 to 5 times a week

☐ 5 or more times a week ☐ I (member) choose not to answer this question

Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you (member)?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

☐ I (member) choose not to answer this question

Have you (member) or any family members with whom you live been unable to get these items or services in the past year? (Check any of the following)

Item			
Food	☐ Yes	☐ No	☐ N/A
Utilities	☐ Yes	☐ No	☐ N/A
Clothing	☐ Yes	☐ No	☐ N/A
Child care	☐ Yes	☐ No	☐ N/A
Medicine or any health care (e.g., Medical, Dental, Mental Health, and/or Vision)	☐ Yes	☐ No	☐ N/A
Phone	☐ Yes	☐ No	☐ N/A
Other:			

Do you (member) need help with activities of daily living, such as bathing, preparing meals, shopping, and/or managing finances?

☐ Yes ☐ No

If you (member) need help with activities of daily living, how much help do you (member) need?

☐ I (member) don't need help.

☐ I (member) get the help I (member) need.

☐ I (member) need a lot more help.

☐ I (member) need a little more help.

Signs of Domestic Violence

We like to ask all members about the following questions because we understand how domestic violence can affect your overall health. You have the option of not answering any of the questions if it makes you feel uncomfortable. These questions are confidential and cannot be shared with anyone without your written permission. However, under required mandatory reporting laws information shared pertaining to child abuse, abuse of disabled person, abuse of an elderly adult, gunshot wounds or life-threating injuries may be reported.

Have you ever been hit, kicked, punched, slapped, or shoved by your partner?

☐ Yes ☐ No

Does your relationship make you feel threatened, ashamed or unsafe at home?

☐ Yes ☐ No **If no**, please proceed to next section.

If you answered yes to any of the above and feel comfortable sharing.
Has the relationship gotten worse, or is it getting scarier?

☐ Yes ☐ No

Does your partner ever watch you closely, follow you or stalk you?

☐ Yes ☐ No

If your partner is here with you today, are you afraid to leave with him/her?

☐ Yes ☐ No

Does your partner ever force you to have sex when you don't want to?

☐ Yes ☐ No

Are there children in the home?

☐ Yes ☐ No

If yes, have there been threats or direct abuse of the children?

☐ Yes ☐ No

Resources:

State Abuse Hotline number: **800-962-2873 (800-96-ABUSE)**

State Domestic Violence Hotline number: **800-500-1119**

State Rape Crisis Hotline number: **888-956-7273 (888-956-RAPE)**

Humana Care Managers are also available: **800-229-9880**

E: Women's Health. If not applicable, please skip.

In the past year, have you (member) had a pap test for cervical cancer?

☐ Yes ☐ No ☐ Does not apply

Are you (member) pregnant?

☐ Yes ☐ No ☐ N/A

E1: If you (member) are pregnant: If not applicable, please skip to section E2.

a. When are you (member) due? _____

b. Has the Florida Department of Children and Families (DCF) been notified of the pregnancy?

☐ Yes ☐ No

If No, please contact DCF to inform them of the pregnancy.

c. Have you (member) been diagnosed with high blood pressure during this pregnancy?

☐ Yes ☐ No

d. Do you (member) currently have diabetes, or have you been diagnosed with diabetes during this pregnancy?

☐ Yes ☐ No

e. Have you (member) been referred to see a high-risk obstetrics (OB) doctor during this pregnancy?

☐ Yes ☐ No

f. If referred to a high-risk OB doctor, what was the reason for the referral

_____

_____

E2: Have you (member) been pregnant before?

☐ Yes ☐ No ☐ Yes, but never delivered live birth

If you (member) have been pregnant before, have you (member):

a. Delivered a baby before 37 weeks of pregnancy?

☐ Yes ☐ No

b. Delivered a baby in the last 6 months?

☐ Yes ☐ No

c. Had a Cesarean section?

☐ Yes ☐ No

Member ID _____

Pregnancy Prevention

What method do you currently use to prevent a pregnancy, if applicable?

- ☐ Condoms
- ☐ Oral contraceptives
- ☐ Foam, spermicides, film, or suppositories
- ☐ Depo Provera shot, IUDs or implants
- ☐ Rhythm method or withdrawal
- ☐ Tubal ligation
- ☐ Vasectomy
- ☐ Hysterectomy
- ☐ Nothing
- ☐ I/my partner and I are trying to get pregnant
- ☐ N/A

If nothing is selected above, please be sure to discuss risks, such as sexually transmitted illnesses (STIs) like chlamydia or gonorrhea, in addition to pregnancy prevention, during your next visit with your primary care physician (PCP).

F: Members 3 years old and younger. If not applicable, please skip to section G.

Was the child (member) born more than five weeks before their expected delivery date?

☐ Yes ☐ No

Did the child (member) have any complications, such as vision, respiratory, or feeding and growth development?

☐ Yes ☐ No

Is child meeting their developmental milestones? (e.g., at 2 months holds head up when on tummy; at 6 months rolls from tummy to back; at 12 months pulls up to standing position; at 18 months able to drink from a cup)

☐ Yes ☐ No

G: Members 20 Years old and younger. If not applicable, please skip, answer the final question, sign, and send to us.

Do you (member) have any concerns about the child's (member's) development or behavior at home or in school?

☐ Yes ☐ No

Is the child (member) up to date on all immunizations?

☐ Yes ☐ No

If no, why not?

- ☐ Just late
- ☐ Barrier (such as transportation, childcare, or choice)
- ☐ Religious or personal preference

Member ID _____

Is the child (member) exposed to secondhand smoke, such as from cigarettes or vaping?

☐ Yes ☐ No

Does the child (member) smoke e-cigarettes, vape, or use smokeless tobacco?

☐ Yes ☐ No

Does the child (member) often worry about or fear something that significantly affects daily health and activities?

☐ Yes ☐ No

In the past 6 months, has the use of alcohol or drugs had an impact on the child's (member's) life?

☐ Yes ☐ No

Do you (member) need assistance and would like to speak with a nurse case manager, behavioral health professional or social worker? (Check all that apply)

☐ Yes, I would like to speak with a nurse case manager for assistance with my medical health and disease management

☐ Yes, I would like to speak with a behavioral health professional for assistance with my mental health

☐ Yes, I would like to speak with a social worker for help with community-based resources

☐ No, I am not in need of assistance at this time

In general, how would you (member) rate your health?

☐ Very good ☐ Good ☐ Fair ☐ Poor

☐ Other: _____

Additional comments

_____

_____

_____

_____

_____

_____ _____

Signature Date

ENGLISH: This information is available for free in other languages and formats. Please contact our Customer Service number at **800-477-6931**. If you use **TTY**, call **711**, Monday – Friday, 8 a.m. to 8 p.m.

SPANISH: Esta información está disponible gratuitamente en otros idiomas y formatos. Comuníquese con nuestro Servicio al Cliente llamando al **800-477-6931**. Si usa un **TTY**, marque **711**. El horario de atención es de lunes a viernes de 8 a.m. a 8 p.m.

CREOLE: Enfòmasyon sa a disponib gratis nan lòt lang ak fòma. Tanpri kontakte nimewo Sèvis Kliyan nou an nan **800-477-6931**. Si ou itilize **TTY**, rele **711**, Lendi - Vandredi, 8 a.m. a 8 p.m.

FRENCH: Ces informations sont disponibles gratuitement dans d'autre langues et formats. N'hésitez pas à contacter notre service client au **800-477-6931**. Si vous utilisez un appareil de télétype **(TTY)**, appelez le **711** du lundi au vendredi, de 8h00 à 20h00.

ITALIAN: Queste informazioni sono disponibili gratuitamente in altre lingue e formati. La preghiamo di contattare il servizio clienti al numero **800-477-6931**. Se utilizza una telescrivente **(TTY)**, chiami il numero **711** dal lunedì al venerdì tra le 8 e le 20:00.

RUSSIAN: Данную информацию можно получить бесплатно на других языках и в форматах. Для этого обратитесь в отдел обслуживания клиентов по номеру **800-477-6931**. Если Вы пользователь **TTY**, звоните по номеру **711** с понедельника по пятницу, с 8.00 до 20.00.

Call If You Need Us

If you have questions or need help reading or understanding this document, call us at **800-477-6931 (TTY: 711)**. We are available Monday through Friday, from 8 a.m. to 8 p.m. Eastern time. We can help you at no cost to you. We can explain the document in English or in your first language. We can also help you if you need help seeing or hearing. Please refer to your Member Handbook regarding your rights.

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **800-477-6931** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the
  U.S. Department of Health and Human Services, Office for Civil Rights
  electronically through their Complaint Portal, available at
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services, free of charge, are available to you. **800-477-6931 (TTY: 711)**

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Humana Healthy Horizons in Florida is a Medicaid product of Humana Medical Plan, Inc.

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **800-477-6931 (TTY: 711)**.

Español: (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **800-477-6931 (TTY: 711)**.

Kreyòl Ayisyen: (French Creole) ATANSYON: Si w pale Kreyòle Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **800-477-6931 (TTY: 711)**.

Tiếng Việt: (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **800-477-6931 (TTY: 711)**.