Office for Family Independence

Maine Department of Health and Human Services

Application for Long Term Care MaineCare

If you need help filling out this application or have questions, please contact us at 1-855-797-4357 or Maine Relay 711 (TTY) – we can help!

How do I apply?

Fill out this application by answering as many questions as you can. We will accept your application if it is submitted with a name, address, and signature. The date we get this information will establish a start date for benefits. This application is also available online at www.mymaineconnection.gov.

What may I need to apply?

We ask about income and other information to determine what medical assistance you qualify for. You may be asked for:

- Social Security Numbers or immigration document numbers for any eligible immigrants who need coverage.
- Income information for you and your spouse (like pay stubs, tax statements, award or benefit letters).
- Information about health insurance available to your household, including Medicare
- Information about current asset and any asset cashed in, closed, sold, transferred, or otherwise liquidated during the 60 months prior to application

We will attempt to verify your information electronically with other federal and state agencies. You may also send in proof with this application. Do not delay applying because something is not immediately available to you. This information can be obtained later in the application process.

Where do I return the application?

Mail: Office for Family Independence
State of Maine – DHHS
114 Corn Shop Lane
Farmington, ME 04938

Fax: 1-207-778-8429

What happens next?

We will review your application and contact you if any additional documents or information is needed. You'll get an eligibility notice of the results after your application is processed.

How can I get help with this application?

- Phone: Call us at 1-855-797-4357 or Maine Relay 711 (TTY)
- In-Person: Visit your local Office for Family Independence (OFI).

Long Term Care eligibility units are based out of the following offices:

Augusta Long Term Care	Portland Long Term Care	Machias Long Term Care
Office for Family Independence 35 Anthony Ave Augusta, ME 04333-0011	Office for Family Independence 151 Jetport Blvd Portland, ME 04102-1946	Office for Family Independence 38 Prescott Drive Machias, ME 04654-9984

In person assistance is available at all OFI office locations: https://www.maine.gov/dhhs/about/contact/offices

If you need help in your language (including an interpreter) or a disability accommodation, call 1-855-797-4357 or Maine Relay 711 (TTY). These services are free.

Please tear off and keep this page for your records.

Long Term Care Programs

Nursing Facility Care

Assistance to help with the cost of services for individuals who are expected to stay at least 30 days in a Nursing Facility. Nursing facilities provide care or rehabilitative services for persons with a disability, injury, or are sick and in need of daily care that can only be provided in a nursing facility. A third party will assess the medical need of the applicant to see if they medically qualify for this benefit.

Residential Care Facility

Help with the cost of services for individuals who expect to stay at least 30 days in a residential care facility. These facilities are for individuals that require less medical care than those in a nursing facility but still need services such as meals, homemaking, personal care, and/or medication administration.

Home and Community Benefits Waiver for Older Adults and Adults with Disabilities (Section 19)

Assistance to help with the cost of in-home care and other services, designed as a package, to help eligible adults remain in their homes. To be eligible for this waiver, an applicant must meet nursing facility level-of-care requirements.

Support Services Waiver for Members with Intellectual Disability or Autistic Disorders (Section 29)

Assistance to help with the cost of support services for adults with intellectual disabilities or Autistic Disorder who live either with their families or live on their own. To be eligible for this waiver, an applicant must require Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care as set forth under the MaineCare Benefits Manual, Chapter II, Section 50.

Home and Community Benefits Waiver for Members with Intellectual Disabilities or Autistic Disorder (Section 21)

Assistance to help with the cost of support services for adults with intellectual disabilities or Autistic Disorder who live in their own home or in another home in the community. Assistance is provided in a community-based setting as an alternative for members who qualify to live in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The assistance provides supplements, rather than replaces supportive, natural personal, family, work, and community relationships and complements.

Home and Community Based Waiver Benefits for Adults with Brain Injury (Section 18)

Assistance to help with the cost of applicable services available adults with brain injury who are 18 or older, meet criteria for care in an intermediate care facility or nursing facility and who choose to live in the community with the support of this waiver. This waiver is designed to maximize the opportunity for members to achieve the greatest degree of self-sufficiency and independence chosen by the member.

Home and Community Based Waiver Benefit for Adults Age 21 and Older with Other Related Conditions (Section 20)

Assistance to help with the cost of applicable services available to adults with Other Related Conditions (ORC) who are 21 or older, meet institutional level of care and choose to live in the community with the support of this waiver. This waiver is designed to maximize the opportunity for members to achieve the greatest degree of self-sufficiency and independence chosen by the applicant.

Social Security Numbers (SSN)

All persons applying for medical assistance must provide a Social Security Number (SSN), if they have one (See 42 CFR §435.910; 42 CFR §457.340). A SSN is not required if the applicant is not eligible to receive an SSN, does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 CFR §422.104, or refuses to obtain an SSN because of well-established religious objections. If you need help getting an SSN, we may be able to help. Call us at 1-855-797-4357. You can also visit www.ssa.gov or call the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778).

Some lawfully present people may not have or be eligible for an SSN. They can still apply for assistance without an SSN. You don't need to provide immigration status or SSNs for household members who aren't seeking coverage but providing an SSN can speed up the application process. We'll keep all information you provide private and secure as required by law.

SSNs are used to conduct electronic data matches with state and federal agencies to verify information you provide and determine your eligibility for medical assistance programs. If the information you provide does not match the information we get from these agencies, we may ask you to send us proof.

What do you want to apply for?

☐ **Nursing Facility Care**
☐ **Residential Care**
☐ **Older Adults & Adults with Disabilities (Section 19)**
☐ **Waiver for Intellectual Disability or Autistic Disorders (Section 21)**
☐ **Support Service Waiver (Section 29)**
☐ **Other Related Conditions Waiver (Section 20)**
☐ **Adults with Brain Injury Waiver (Section 18)**

Do you need help with medical bills incurred within the past three (3) months? ☐ Yes ☐ No

If yes, which months? _____

You must provide proof of your income, assets, and medical expenses for each of the months you are requesting coverage.

Information about you, the applicant

A SSN is required for every person applying for health care coverage, if they have one. You do not have to give us the SSN for people in your home that are not applying for coverage but providing an SSN may help speed up the application process.

Name (first, middle initial, last):	Social Security Number:
Gender: ☐Male ☐ Female ☐ Non-binary	Date of Birth:
Marital Status:	☐ Never Married ☐ Married - marriage date: _____ ☐ Separated ☐ Divorced ☐ Widowed - date of death of your spouse: _____
Home Address:	
Mailing Address (if different from home address):	
Phone Number:	Phone Type: ☐ Cell ☐ Home ☐ Work Preferred language:
Email Address:	

Go paperless! If you want electronic notices, you must set up an account online at www.mymaineconnection.gov

Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

If yes, are you a naturalized or derived citizen? (This usually means you were born outside of the U.S.)
☐ Yes, please provide an alien and certificate number. ☐ No

Alien Number: _____ Certificate Number: _____

If you aren't a U.S. citizen or U.S. national, do you have an immigration status? See page 10 for a list of immigration statuses.
☐ Yes, please answer the questions below. ☐ No

Immigration status: _____ Alien# or USCIS#: _____

Document type: _____ Card or Document Number: _____

Did you enter the United States before August 22, 1996? ☐ Yes ☐ No

Are you, or is your spouse or parent, a veteran or active-duty member of the military? ☐ Yes ☐ No

Providing race and ethnicity data is optional; it will not affect your eligibility or the amount of benefits your household may receive. This information is collected to help us better understand and improve our programs and benefit delivery.

Ethnicity (*Optional*): ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Race (*Optional – check all that apply*): ☐ White ☐ Black/African American ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ American Indian/Alaskan Native ☐ Other_____

Are you now, or have you in the past 90 days been in a hospital, nursing facility, or residential care facility? ☐ Yes ☐ No
If yes, list below.

Facility Name	Facility Address	Admission Date	Discharge Date

Information about your spouse

If applicable, fill out this part for your spouse who lives with you.

A SSN is required for every person applying for health care coverage, if they have one. You do not have to give us the SSN for people in your home that are not applying for coverage but providing an SSN may help speed up the application process.

Name (first, middle initial, last):	Social Security Number:	Date of Birth:

Gender: ☐Male ☐ Female ☐ Non-binary

Does your spouse live with you? ☐ Yes ☐ No – provide address below

Spouse's Home Address:

Spouse's Mailing Address (if different from home address):

Is your spouse applying for MaineCare? ☐ **Yes** – Answer the questions below. ☐ **No** – Skip to next Person.

Are they a U.S. citizen or U.S. national? ☐ Yes ☐ No

If yes, are you a naturalized or derived citizen? (This usually means you were born outside of the U.S.)
☐ Yes, please provide an alien and certificate number. ☐ No

Alien Number: Certificate Number:

If they aren't a U.S. citizen or U.S. national, do they have an immigration status? See page 10 for a list of immigration statuses.
☐ Yes, please answer the questions below. ☐ No

Immigration status: Alien# or USCIS#:

Document type: Card or Document Number:

Did they enter the United States before August 22, 1996? ☐ Yes ☐ No

Are they a veteran or active-duty member of the military? ☐ Yes ☐ No

Ethnicity (*Optional*): ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Race (*Optional – check all that apply*): ☐ White ☐ Black/African American ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ American Indian/Alaskan Native ☐ Other_____

Other Members of Your Household

Are there other family members living with you? ☐ Yes ☐ No

Name (first, middle initial, last)	Date of Birth	Relationship to you

Are you or is any applicant in your household American Indian or Alaska Native? ☐ Yes ☐ No

Name of person	Tribe Name

Income

Do you or your spouse receive any income? ☐ Yes – list income on the next page. ☐ No

To speed up the eligibility process, please send in proof of income (e.g., pay stubs, award letters, etc.). If proof is not submitted, and we are unable to verify your income through electronic data sources, you will be asked to submit proof.

Examples of income types:

Social Security Retirement (SSA/SSR)	*Retirement or pension payments*	*Alimony/Spousal Support*
Social Security Disability (SSDI)	*Workers Compensation*	*Dividend or Interest*
Supplemental Security Income (SSI)	*Civil Service or Other Annuity Payments*	*Payment from Trusts*
Veterans (VA) Compensation	*Earnings (wages)*	*Self-employment*
Veterans (VA) Aid and Attendance	*Disability Payments*	*Unemployment*
Veterans (VA) Pension	*Rental Income*	*Any other payments*

Your Income	Gross Amount	How often received?
Example – Social Security Retirement	$*876.00*	*Monthly*
	$	
	$	
	$	

Your Spouse's Income	Gross Amount	How often received?
	$	
	$	
	$	

Assets

Please tell us about assets you or your spouse own or have an interest in. You will need to send in proof of all assets.

Examples of assets include:

Cash	*Resident Account*	*Stocks/Bonds*	*Trust Funds*
Checking/Saving Account	*Certificate of Deposit (CD)*	*Safe Deposit Box*	*Annuities*
IRA, 401K, or 403B	*Deferred Compensation*	*Direct Express Card/Account*	*Promissory Note*

Name(s) on Account	Type of Asset	Name of Bank or Institution	Current Value
Example – Jane	*Checking*	*North Bank*	$*4,600*
			$
			$
			$
			$
			$
			$

Vehicles

Do you or your spouse own, or jointly own, any vehicles? ☐ Yes – list below. ☐ No

Examples of vehicles:

Cars/Trucks	*Campers/RV*	*ATVs*	*Tractors*	*Boats*
Motorcycles	*Trailers*	*Snowmobiles*	*Aircraft*	*Farm Equipment*

Owner Name(s)	Vehicle Type	Year	Make/Model	Amount Owed
				$
				$

Primary Residence

Do you own a home which is a primary residence? ☐ Yes – list below. ☐ No

Owner(s)	Primary Residence Full Address	Amount Owed

Would you return to your residence if you no longer need care in a Nursing Facility or Residential Care Facility? ☐ Yes ☐ No

Other Property

Do you or your spouse own, or jointly own, any other property? ☐ Yes – list below. ☐ No

Examples of property:

Land *House* *Camp* *Life Estate* *Timeshare* *Rental Property* *Buildings*

Owner(s)	Property Type	Full Address of Property	Amount Owed
			$
			$
			$
			$

Life Insurance

Do you or your spouse have any life insurance policies? ☐ Yes – list below. ☐ No

Policy Owner:	Insurance Company Name:		
Type ☐ Term ☐ Whole	Policy Number	Face Value $	Cash Surrender Value $

Policy Owner:	Insurance Company Name:		
Type ☐ Term ☐ Whole	Policy Number	Face Value $	Cash Surrender Value $

Burial Funds

Do you or your spouse have a funeral plan, pre-paid burial, or mortuary trust? ☐ Yes – list below. ☐ No

Who is it for?	Where are the funds held?	Is it irrevocable?	Value
		☐ Yes ☐ No	$
		☐ Yes ☐ No	$

Does your name or your spouse's name appear on anyone else's assets, financial accounts, or any type of property other than those already listed? ☐ Yes ☐ No

If yes, explain:

Have you or your spouse recently received, or do either of you expect to receive, any retroactive government benefits, pay raises, lawsuit settlement, inheritances, lottery winnings, or compensation of any other kind? ☐ Yes ☐ No

If yes, explain:

Asset Transfers

Have you, your spouse, or anyone acting on your or your spouse's behalf disposed of, sold, or given away anything of value within the last 60 months? ☐ Yes – list transferred assets below. ☐ No

Description of item given away	Value	Person who gave item away
	$	
	$	
	$	
	$	
	$	
	$	

Have you, your spouse, or anyone acting on your or your spouse's behalf closed any savings, checking, or any other financial accounts within the last 60 months? ☐ Yes – list closed accounts below. ☐ No

Type of account closed	Date Closed	Reason for closure

Expenses

If you are in a hospital or nursing facility, does your spouse live at home and pay shelter expenses?
☐ Yes – please list expenses below. ☐ No

Expense Type	How much?	How often paid?	Who Pays this expense?	Who is it paid to?
Mortgage	$			
Rent	$			
Property Taxes	$			
Home Insurance	$			
Heat	$			
Electricity	$			
Telephone	$			
Water/Sewer	$			

Is your heating cost included in your rent? ☐ Yes ☐ No

Does your mortgage payment include taxes and insurance? ☐ Yes ☐ No

Does anyone else live in the household of your spouse? ☐ Yes ☐ No

Medicare

Do you have Medicare coverage? ☐ Yes ☐ No Medicare Number: _____

Part A Coverage Start Date: _____ Part B Coverage Start Date: _____

Part A Premium Amount: $ _____ Part B Premium Amount: $ _____

Does your spouse have Medicare coverage? ☐ Yes ☐ No Medicare Number: _____

Part A Coverage Start Date: _____ Part B Coverage Start Date: _____

Part A Premium Amount: $ _____ Part B Premium Amount: $ _____

Other Medical Insurance Information

Do you or your spouse have other medical insurance? ☐ Yes ☐ No If yes, list below.

Examples of insurance:
Health Insurance *Dental Insurance* *Vision Insurance* *Medicare Supplement Plan*

Type	Name of Insured	Insurance Company	Policy Number	Premium Amount	How Often Paid
				$	
				$	

Do you or your spouse have any Long Term Care Insurance? ☐ Yes ☐ No If yes, list below.

Name of Insured	Name of Insurance Company	Policy Number

Assistance with Application

Do you have a power of attorney, conservator, or court-ordered guardian? ☐ Yes ☐ No

Person's Name: _____ Type: _____

Address: _____ Phone: _____

Please provide a copy of the court order or the power of attorney.

Is there someone else who knows about your financial situation (such as a family member or authorized representative), and whom we may contact to help with this application? ☐ Yes ☐ No

Person's Name: _____

Address: _____ Phone: _____

To appoint an authorized representative please complete ***Appendix A.***

Did someone help you fill out this form? ☐ Yes ☐ No

Person's Name: _____ Phone: _____

Acknowledgements

Annuity Disclosure: To qualify for long term care services through MaineCare, the Deficit Reduction Act (DRA) of 2005 requires you to tell us about any annuity that you or your spouse have an interest in. Annuities purchased on or after February 8, 2006, must name the State of Maine as a remainder beneficiary. If there is a community spouse and/or minor or disabled child, they may be name prior to the State of Maine. The State of Maine will only recoup on an amount equal to the claims MaineCare paid; any excess will be available to a secondary beneficiary or the estate of the annuitant.

Please check any that apply:

☐ I have at least one annuity.
☐ My spouse has at least one annuity.
☐ My spouse/I do not have any annuities.

Estate Recovery: If you are age 55 or older and receive MaineCare (Maine Medicaid) to pay for nursing facility services, home and community-based services, or any related hospital and prescription drug services related to these services, the State may make a claim on the assets of your estate (upon your death) to recover the money that MaineCare has paid for these services. No claim will be made if the only benefit you get is Medicare Savings Program. For more information about estate recovery call 1-800-977-6740.

Sign Here This application cannot be accepted without a signature.

I understand that information provided on this form may be verified by financial institutions, consumer reporting, and federal, state, and local agencies. If information cannot be verified, I agree to provide documents to prove what I have stated on this application. If I have given incorrect information, my benefits may be denied.

I understand that if anyone applying is eligible for MaineCare (Medicaid or CubCare), I am giving the Medicaid agency the right to pursue and collect payment from any other health insurance, legal settlements, or other third parties who may be responsible for paying for our health costs. I am also giving the Medicaid agency rights to pursue and get medical support from a parent.

If a MaineCare eligible child has a parent who lives outside of my home, I know I will be asked to cooperate with the agency that collects medical support from the absent parent. If I think cooperating to collect medical support will harm me or my children, I can tell the Office of Family Independence and I may not have to cooperate.

I am signing this application under penalty of perjury, which means to the best of my knowledge I have given true, correct, and complete answers to all questions on this form for all person applying for benefits. I know that I must tell the Office for Family Independence if anything changes and is different than what I wrote on this application. I understand that a change in my information could affect my eligibility as well as eligibility for member(s) of my household. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.

X

Your signature or your authorized representative's signature	**Date Signed**

Notification of Right to Request a Hearing

We will give you a written notice explain your benefits. If you do not agree with the Department eligibility decision, you have the right to appeal. You can ask for a hearing by contacting the Office for Family Independence, over the phone, in writing, or in person at your local office.

Non-Discrimination Notice

The Department of Health and Human Services (DHHS) does not discriminate on the basis of disability, race, color, sex, gender, sexual orientation, age, national origin, religious or political belief. Questions, concerns, complaints or requests for additional information regarding the ADA and programs, services, or activities may be forwarded to the DHHS ADA/Civil Rights Coordinator, at 11 State House Station, Augusta, Maine 04333-0011; 207-287-3707 (V); Maine Relay 711 (TTY); or ADA-CivilRights.DHHS@maine.gov.

Civil rights complaints may also be filed with the U.S. Department of Health and Human Services, Office of Civil Rights, by phone at 1-800-368-1019 or 1-800-537-7697 (TDD); by mail to 200 Independence Avenue, SW, Room 509, HHS Building, Washington, D.C. 20201; or online through Office of Civil Rights (OCR) Complaint Portal at https://ocrportal.hhs.gov/ocr/.

Voter Registration

If you are not a registered to vote where you live now and would like to apply to register to vote, you can download and print a Maine voter registration application at https://www.maine.gov/sos/cec/elec/voter-info/voterguide.html. Applying to register or declining to register to vote will not affect services or benefits from this agency.

Appendix A: Appointment of an Authorized Representative

You have the right to appoint an authorized representative to act on your behalf with the Department. If you want to name a person or organization as your authorized representative, use this form.

We are committed to the privacy of your health information. Please read this form carefully.

Individual's Name: _____

Date of Birth: _____ Social Security Number: _____

Individual's Address: _____

I (individual named above) herby appoint the following individual/organization to act as Authorized Representative for me.

Authorized Representative's Name: _____

Address: _____

Telephone Number: _____ Email Address: _____

Existing legal authority (if any) for individual to act on my behalf (check all that apply):

☐ Guardianship ☐ Power of Attorney ☐ Advance Healthcare Directive

☐ Other (explain): _____

By making this appointment, I want my Authorized Representative to (check all that apply):

☐ Sign and submit an application on my behalf (including an electronic application)
☐ Sign and submit a recertification form on my behalf (including an electronic application)
☐ Receive copies of Notices of Decisions and all other written communications from the Department
☐ Obtain SNAP benefits on behalf of my household
☐ Represent me at fair hearings
☐ Other (please describe):
☐ Act on my behalf in all other matters with the Department of Health and Human Services

- My authorized representative's authority is limited to the task or tasks I have delegated, above.
- This appointment is valid until:
  - I change this appointment in writing by notifying the Department that this Authorized Representative is no longer authorized to act on my behalf; or
  - My Authorized Representative informs the Department in writing that he/she is no longer acting as my Authorized Representative.
- I understand that taking back this appointment does not apply to any documents signed by or sent to my Authorized Representative before I took back the appointment.
- I understand that if I want my Authorized Representative to receive copies of the Notices of Decisions and all other written communications from the Department, the information shared will be for all programs in which I participate that are administered by the Department.

I am signing this form voluntarily, and I have the right to a signed copy of this form if I request one.

Signature of the Individual: _____ Date: _____

For the Authorized Representative

I (Individual Named as Authorized Representative) hereby agree to:

- Fulfill all above-designated responsibilities on behalf of the individual who appointed me as their Authorized Representative;
- Maintain the confidentiality of any information regarding the individual who appointed me as their Authorized Representative;
- Adhere to the regulations 42 C.F.R. § 431(F) and at 45 C.F.R §155.260(f) (relating to confidentiality of information), 42 C.F.R. §447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as all other applicable state and federal laws concerning conflicts of interest and confidentiality of information.

Signature of the Authorized Representative: _____ Date: _____

Immigration Statuses and Document Types

For applicants who are not U.S. citizens: Information about current immigration status is needed to determine eligibility. We will attempt to verify declared immigration status through an electronic data match. It may help us process this application faster if you include a copy of immigration documents for all individuals who are applying.

See the list below for common document types. If your status isn't listed here, you can write in another status or choose to leave the question blank. If needed, we will send you a letter to get more information.

If information regarding immigration status is not provided the individual may only be eligible for coverage of emergency services.

Immigration Status	Document Types
• Refugee • Asylee • Granted Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) • Cuban or Haitian entrant • Amerasian • Victim of trafficking and their spouse, child, sibling, or parent • Afghan or Iraqi special immigrant visa holder • Citizen of Compact of Free Association (Micronesia, the Marshall Islands, and Palau) • Lawful Permanent Resident (LPR/Green Card holder) • Battered non-citizens and spouse, child, or parent • Paroled into the U.S. for at least one year • Conditional entrant granted before 1980 • Member of a federally recognized Indian tribe or American Indian born in Canada • Non-immigrant status (worker visas, student visas, U-visa, T-visa, and other visas) • Paroled into the U.S. for less than one year • Lawful temporary resident • Temporary Protected Status (TPS) or applicant for TPS with employment authorization • Granted employment authorization • Family Unity beneficiaries • Deferred Enforced Departure (DED) • Deferred Action Status except for Deferred Action for Childhood Arrivals (DACA) • Pending application for Special Immigrant Juvenile status • Adjustment to LPR Status with an approved visa petition • Granted an administrative stay of removal • Applicant for asylum or for Withholding of Removal, under immigration laws or under the Convention against Torture (CAT) who has either been granted employment authorization, OR is under 14 and has had an application pending for at least 180 days • Resident of American Samoa • Other	• Permanent Resident Card, "Green Card" (I-551) • Reentry Permit (I-327) • Refugee Travel Document (I-571) • Employment Authorization Document (I-766) • Machine Readable Immigrant Visa (with temporary I-551 language) • Temporary I-551 Stamp (on passport or I-94/I-94A • Arrival/Departure Record (I-94/I-94A) • Arrival/Departure Record in foreign passport (I-94) • Foreign Passport • Certificate of Eligibility for Nonimmigrant Student Status (I-20) • Certificate of Eligibility for Exchange Visitor Status (DS-2019) • Notice of Action (I-797) • Document indicating membership in a federally recognize Indian tribe or American Indian born in Canada • Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR) • Document indicating withholding of removal • Office of Refugee Resettlement (ORR) eligibility letter (if under 18) • Resident of American Samoa card • Alien number (also called alien registration number or USCIS number) or I-94 number

Get help in a language other than English

Language assistance services, free of charge, are available to you. Call 1-877-797-4357 (TTY: 711)

Français (French)	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-797-4357 (ATS: 711).
español (Spanish)	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-797-4357 (TTY: 711).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-797-4357 (TTY: 711）。
Afaan Oromoo (Cushite-Oromo)	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-797-4357 (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 1-855-797-4357 (TTY: 711).
العربية (Arabic)	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 855-797-4357-1 (رقم هاتف الصم والبكم 117).
ខ្មែរ (Cambodian)	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-797-4357 (TTY: 711)។
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-797-4357 (телетайп: 711).
Tagalog (Tagalog)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-797-4357 (TTY: 711).
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-797-4357 (TTY: 711).
ภาษาไทย (Thai)	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-797-4357 (TTY: 711).
Thuɔŋjaŋ (Nilotic – Dinka)	PIŊ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-855-797-4357 (TTY: 711).
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-797-4357 (TTY: 711) 번으로 전화해 주십시오.
Polski (Polish)	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-797-4357 (TTY: 711).
日本語 (Japanese)	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-797-4357 (TTY: 711）まで、お電話にてご連絡ください。
Português (Portuguese)	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-797-4357 (TTY: 711).
Kiswahili (Swahilli)	KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-855-797-4357 (TTY: 711).
Ikirundi (Bantu – Kirundi)	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-855-797-4357 (TTY: 711).
رسی (Farsi)	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-797-4357 (TTY: 711) تماس بگیرید.
Ikiyarwanda (Kinyarwanda)	ICYITONDERWA: Nimba uvuga Ikinyarwanda, uzahabwa serivisi zo kugufasha mundimi. Hamagara 1-855-797-4357 (TTY: 711)
Lingala (Lingála)	KEBA, soki olobaka Lingala, yeba ete lisalisi ya mobongoli ya lonkota olobaka epesamaka ofele. Benga 1-855-797-4357 (ATS: 711).
دری (Dari)	1-855-توجه: اگر به زبان دری صحبت می کنید، سهولت های زبانی بطور رایگان برای شما فراهم می شود. با 797-4357 (TTY: 711).تماس بگیرید