Application for CSOC Summer Camp Services 2025

NJ Children's System of Care
Contracted System Administrator — **PerformCare®**

Part A: Financial Support toward Summer Camp Tuition

Your child must be determined eligible for Intellectual/Developmental Disability Services by CSOC and registered for a Qualified Camp prior to submitting this application. If you do not know your child's CYBER ID, please contact PerformCare at **877-652-7624**. You can also complete the Summer Camp Services application online at **www.performcarenj.org/summercamp**.

Instructions

1. Select a Qualified Camp from the **CSOC-approved** list available at: **www.performcarenj.org/summercamp**.
2. If the Qualified Camp has determined your child will require the assistance of a **One-to-One Aide/Advocate** to attend camp, **you must complete Part B of this application**. Prior to submitting your request, please contact the One-to-One Aide Provider Agency to make sure the agency you selected can staff your request. The list of CSOC-approved providers can be found at: **www.performcarenj.org/summercamp**.
3. Mail the **completed** application along with a **copy of the registration or acceptance letter** from the Qualified Camp to: **PerformCare, Attn: Summer Camp Services, 300 Horizon Drive, Suite 306, Robbinsville, NJ 08691-1919**. Your application **must be complete and postmarked** or received **no later than June 30, 2025**, to be considered for financial support. Applications will not be accepted after the June 30 deadline. Application status notifications will be mailed after December 1, 2024, and March 1, 2025.

Please Note: **Payment is made to the Qualified Camp the youth attends after camp services are rendered.**

Child Information		
Child's First Name	Child's Last Name	
CYBER ID#	Date of Birth	ZIP Code

Parent/Legal Guardian Information			
Parent/Legal Guardian First Name		Parent/Legal Guardian Last Name	
Address		City	State
ZIP Code	Phone	Email	

Qualified Camp Information — Please submit Camp Registration Confirmation with this Application.			
Qualified Camp Name		Camp ID (Found on the Qualified Camp Provider list on our website)	
Address		City	State
ZIP Code	Phone	Email	

Qualified Camp Information — Please submit Camp Registration Confirmation with this Application.
Type of Camp:
☐ **Overnight Camp** (select up to **6** days for reimbursement):
Camp Name:
Dates: **Start Date (mm/dd/yy)** **End Date (mm/dd/yy)** to **(not to exceed 6 days)**
☐ **Day Camp** (select up to **10** days only for reimbursement):
Week one
Camp Name:
Dates: **Start Date (mm/dd/yy)** **End Date (mm/dd/yy)** to **(not to exceed 5 days)**
Week two
Camp Name:
Dates: **Start Date (mm/dd/yy)** **End Date (mm/dd/yy)** to **(not to exceed 5 days)**
Nonconsecutive Dates for Camp: (If youth is not attending 2 full weeks, please enter individual dates)
Camp Name:

Dates:	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**
	mm/dd/yy	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**

Qualified Camp Information — Please submit Camp Registration Confirmation with this Application.					
Type of Camp (continued)					
☐ **Alternative Recreational Sessions** (select 20 two-hour ARS sessions **OR** 5 days of day camp and 10 ARS sessions)					
ARS Camp Name:					
Dates:	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**
	mm/dd/yy	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**
	mm/dd/yy	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**
	mm/dd/yy	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**

Day Camp Name:					
Dates:	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**

Attestation		
I hereby attest that by submitting the Application for Financial Support toward Summer Camp tuition, that I have fully registered my youth at the indicated Qualified Camp. I further declare that the information entered in this application is true and accurate to the best of my knowledge.		
Parent/Legal Guardian Name	Parent/Legal Guardian Signature	Date

Part B: Application for One-to-One Aide Services for Summer Camp 2025

If the camp has determined your child will require the assistance of a One-to-One Aide/Advocate to attend camp, you must complete this section of the application. You and the camp provider must complete the Child Adaptive Behavior Summary (CABS) together on the following pages in order to apply for One-to-One Aide Services. The camp must retain a copy of the jointly completed CABS.

In addition, a copy of the CABS must be provided to the identified One-to-One Aide Provider Agency as it provides a broad picture of the impact of the child's disability on daily life for both the child and the caregiver and helps ensure the "best fit" of One-to-One Aide for your child. Please also refer to the Qualified One-to-One Aide provider list available on PerformCare's website to complete the application – **www.performcarenj.org/summercamp**.

ATTENTION: Due to high demand for One-to-One Aides for children attending camp the last two weeks of August, CSOC **cannot guarantee** all requests will be filled. **Your application must be complete in order for it to be processed.**

One-to-One Aide Information — For Day Camp and ARS Only

Child Information		
Child's First Name	Child's Last Name	
CYBER ID#	Date of Birth	

One-to-One Aide Provider Information			
One-to-One Aide Provider Agency name	Provider ID (Found on the One-to-One Aide Provider list on our website)		
Address	City	State	ZIP Code
Agency Contact Person	Phone	Email	

Attestation — Your application must be complete in order for it to be processed.		
I hereby attest that I have fully registered my youth at the indicated Camp and have confirmed with the One-to-One Provider Agency that my child's needs can be met through their agency. I further declare that the information entered in this application is true and accurate to the best of my knowledge.		
Parent/Legal Guardian Name	Parent/Legal Guardian Signature	Date

Mail the request to: **PerformCare, Attn: Summer Camp Services, 300 Horizon Drive, Suite 306, Robbinsville, NJ 08691-1919**. This application **must be complete and postmarked** or received **no later than June 30, 2025**, to be considered for One-to-One Aide Services. Application status notifications will be mailed after December 1, 2024, and March 1, 2025. Applications will not be accepted after the June 30, 2025 deadline. If you have any questions, please contact PerformCare at **1-877-652-7624**.

A Child Adaptive Behavior Summary (CABS) Form is to be completed with the Camp Provider.

Child Adaptive Behavior Summary (CABS)

Child's Name: _____ Current Age: _____
First name Middle initial Last name

CABS completed by: _____ Date completed: _____

Relationship: _____ Phone number: _____

SECTION I: ACTIVITIES OF DAILY LIVING

Remember to rate the child's average functioning **at home** within the last **6 months**. You may indicate in the comment boxes any additional information such as intensity, triggers, and whether the child's current functioning has improved or gotten worse compared to past abilities.

EATING	**1** Mostly Independent	**2** Needs Verbal Prompts Less Than Half of the Time	**3** Needs Verbal Prompts More Than Half of the Time	**4** Needs Physical Assistance Less Than Half of the Time	**5** Needs Physical Assistance More Than Half of the Time	**N/A** Not Applicable
1. Eats with fingers	☐	☐	☐	☐	☐	☐
2. Feeds self with a spoon	☐	☐	☐	☐	☐	☐
3. Feeds self with fork	☐	☐	☐	☐	☐	☐
4. Cuts food with a knife	☐	☐	☐	☐	☐	☐
5. Drinks from a cup or glass	☐	☐	☐	☐	☐	☐
Comments/Additional Information: (Briefly explain any N/A responses)						

TOILETING	**1** Mostly Independent	**2** Needs Verbal Prompts Less Than Half of the Time	**3** Needs Verbal Prompts More Than Half of the Time	**4** Needs Physical Assistance Less Than Half of the Time	**5** Needs Physical Assistance More Than Half of the Time	**N/A** Not Applicable
1. Identifies when to use toilet	☐	☐	☐	☐	☐	☐
2. Toilets self	☐	☐	☐	☐	☐	☐
3. Wipes self with toilet paper	☐	☐	☐	☐	☐	☐
4. Washes hands after toileting	☐	☐	☐	☐	☐	☐
5. (Females) Takes care of menstrual needs	☐	☐	☐	☐	☐	☐
6. Any bladder accidents — Daytime	☐	☐	☐	☐	☐	☐
7. Any bladder accidents — Nighttime	☐	☐	☐	☐	☐	☐
8. Any bowel accidents — Daytime	☐	☐	☐	☐	☐	☐
9. Any bowel accidents — Nighttime	☐	☐	☐	☐	☐	☐
10. Uses any incontinence products (diapers or similar)	☐ Yes	☐ No	**IF YES:** Check time(s) of day: ☐ Daytime ☐ Nighttime			
Comments/Additional Information: (Briefly explain any N/A responses)						

HYGIENE	**1** Mostly Independent	**2** Needs Verbal Prompts Less Than Half of the Time	**3** Needs Verbal Prompts More Than Half of the Time	**4** Needs Physical Assistance Less Than Half of the Time	**5** Needs Physical Assistance More Than Half of the Time	**N/A** Not Applicable
1. Turns on/regulates water temperature	☐	☐	☐	☐	☐	☐
2. Washes and dries hands	☐	☐	☐	☐	☐	☐
3. Washes and dries face	☐	☐	☐	☐	☐	☐
4. Bathes self in bathtub	☐	☐	☐	☐	☐	☐
5. Bathes self in shower	☐	☐	☐	☐	☐	☐
6. Shampoos hair	☐	☐	☐	☐	☐	☐
7. Dries self	☐	☐	☐	☐	☐	☐
8. Uses deodorant	☐	☐	☐	☐	☐	☐

HYGIENE	**1** Mostly Independent	**2** Needs Verbal Prompts Less Than Half of the Time	**3** Needs Verbal Prompts More Than Half of the Time	**4** Needs Physical Assistance Less Than Half of the Time	**5** Needs Physical Assistance More Than Half of the Time	**N/A** Not Applicable
9. Combs/brushes hair	☐	☐	☐	☐	☐	☐
10. Puts toothpaste on brush	☐	☐	☐	☐	☐	☐
11. Brushes own teeth	☐	☐	☐	☐	☐	☐
12. Blows and wipes nose with tissue	☐	☐	☐	☐	☐	☐
13. Shaves self as needed	☐	☐	☐	☐	☐	☐
Comments/Additional Information: (Briefly explain any N/A responses)						

DRESSING	**1** Mostly Independent	**2** Needs Verbal Prompts Less Than Half of the Time	**3** Needs Verbal Prompts More Than Half of the Time	**4** Needs Physical Assistance Less Than Half of the Time	**5** Needs Physical Assistance More Than Half of the Time	**N/A** Not Applicable
1. Undresses self (appropriately)	☐	☐	☐	☐	☐	☐
2. Can fasten buttons	☐	☐	☐	☐	☐	☐
3. Can put on clothes with snaps	☐	☐	☐	☐	☐	☐
4. Can pull up/down zippers	☐	☐	☐	☐	☐	☐
5. Fastens a buckle (i.e., belt buckle)	☐	☐	☐	☐	☐	☐
6. Hooks own bra	☐	☐	☐	☐	☐	☐
7. Ties shoes	☐	☐	☐	☐	☐	☐
8. Dresses self completely	☐	☐	☐	☐	☐	☐
9. Changes clothing regularly	☐	☐	☐	☐	☐	☐
10. Selects seasonal clothing	☐	☐	☐	☐	☐	☐
11. Removes socks, hat, and mittens	☐	☐	☐	☐	☐	☐
Comments/Additional Information: (Briefly explain any N/A responses)						

SECTION II: Communications and Social Behaviors

Remember to rate the child's average functioning **at home, in school, and in the community** within the **last 6 months**. You may indicate in the comment boxes any additional information such as intensity, triggers, and whether the child's current functioning has improved or gotten worse compared to past abilities.

COMMUNICATION SKILLS	**1** Almost Never (less than 10% of the time)	**2** Infrequently (less than 25% of the time)	**3** Sometimes (about 50% of the time)	**4** Frequently (More than 75% of the time)	**5** Most/all of the time (90% or more of the time)
1. Responds appropriately to 'Yes' and 'No' questions	☐	☐	☐	☐	☐
2. Follows simple directions	☐	☐	☐	☐	☐
3. Follows complex or multistep directions	☐	☐	☐	☐	☐
4. Communicates basic wants and needs	☐	☐	☐	☐	☐
YES/NO RESPONSE SET:	**YES**	**NO**	**Comment for each below:**		
5. Uses gestures to communicate (such as pointing)	☐	☐			
6. Uses sign language to communicate	☐	☐			
7. Understands gestures	☐	☐			
8. Understands signs or sign language	☐	☐			
9. Answers/able to use a telephone	☐	☐			
10. Does child use any assistive devices for communication?	☐	☐			
SOCIAL BEHAVIORS	**YES**	**NO**	**COMMENTS**		
Does child have hobbies she or he enjoys?	☐	☐			
Child has the ability to independently make friends and maintain friendships.	☐	☐			
Child is able to sustain a meaningful conversation with his/her same age peers.	☐	☐			
Child exhibits interest in spending time with peers close in age.	☐	☐			
Child keeps secret appropriately and is careful about sharing personal information.	☐	☐			
Child is able to exhibit sympathy and concern for the feelings of friends.	☐	☐			
Child is able to express him/herself when necessary.	☐	☐			
Child is able to appropriately manage anger and frustration.	☐	☐			

OTHER AREAS OF FUNCTIONING	YES	NO	COMMENTS
1. Child is able to identify preferences (food, TV shows, games).	☐	☐	
2. Child can plan and anticipate future events.	☐	☐	
3. Child will seek assistance from others when needed.	☐	☐	
4. Child is able to take trash out and place in appropriate container.	☐	☐	
5. Child will point to a favorite or interesting object.	☐	☐	
6. Child has hobbies of interest.	☐	☐	
7. Child can set & carry out plans.	☐	☐	
8. Child is able to master simple tasks.	☐	☐	
9. Child is capable of cleaning their own room (putting objects away).	☐	☐	
10. Child seeks peer companions for play.	☐	☐	
11. Child can tell time on digital clock or watch.	☐	☐	
12. Child Is 3 or more grade levels behind in 2 academic subjects.	☐	☐	
13. Child can communicate primary home address.	☐	☐	
14. Child can identify objects in pictures by pointing or naming.	☐	☐	
15. Child can count from 1 to 10 without mistakes.	☐	☐	
16. Child can match 3 shapes or 3 colors.	☐	☐	
17. Child can identify at least 7 colors.	☐	☐	
18. Child can use time to follow a schedule.	☐	☐	
Additional Comments:			

COMMUNITY AWARENESS	YES	NO	COMMENTS
1. What activities in the community does the child participate in?			
2. Does the child demonstrate appropriate behavior during these activities?	☐	☐	
3. Is the child aware of ordinary household dangers such as stairs, cleaning liquids, heaters, stoves, and fireplaces?	☐	☐	
4. Does the child demonstrate awareness of community dangers like road traffic, over-friendliness to strangers?	☐	☐	
5. Can the child make purchases?	☐	☐	
6. Can the child use public transportation?	☐	☐	
7. Can the child tell time?	☐	☐	
8a. Does the child self-administer any prescribed medication?	☐	☐	
8b. Describe method of administering medication:			
9. Can this person be left alone/unsupervised for any length of time?	☐	☐	
10. Describe the assistance the child needs to manage money (paying bills, budgeting, etc.)			
Comments:			

SECTION III: Medical and Behavioral Factors

Remember to rate the child's average functioning **at home** within the last **6 months**. You may indicate in the comment boxes any additional information such as intensity, triggers, and whether the child's current functioning has improved or gotten worse compared to past abilities.

For Medical Risk Conditions, indicate "yes" only if they have experienced symptoms in the past 6 months, regardless of date of diagnoses. If the child has a past history of the condition/treatment, but does not currently, please indicate "no" but include details of the history in the comments.

For the section on Trauma and Risk History, please indicate yes if the child has **ever** experienced the item listed. If the child has experienced other types of trauma, please indicate that in the appropriate comment box.

MEDICAL RISK CONDITIONS	YES	NO	COMMENTS
1. Allergies (medication, food)	☐	☐	
2. Asthma (inhalers, nebulizers)	☐	☐	
3. Respiratory/ (oxygen, tracheotomy, CPAP)	☐	☐	
4. Gastrointestinal (feeding/elimination issues, severe reflux)	☐	☐	
5. Uses colostomy	☐	☐	
6. At risk for aspiration	☐	☐	
7. Uses G-Tube	☐	☐	
8. Coughs or chokes while eating or drinking	☐	☐	
9. Someone else must put food/liquids in mouth	☐	☐	
10. Needs mechanically altered diet (thickened, chopped/puréed)	☐	☐	
11. Needs medically prescribed diet (fat, sodium, cholesterol)	☐	☐	
12. Displays extreme food/liquid-seeking behaviors	☐	☐	
13. Dehydration risk/regularly refuses liquids	☐	☐	
14. Constipation: regularly requires suppository or enema	☐	☐	
15. Requires catheter, dialysis (kidney/urinary disease, etc.)	☐	☐	
16a. Epilepsy/seizure disorder? If yes, Type	☐	☐	
16b. Is youth prescribed medication for seizures?	☐	☐	
16c. Date of last seizure, type of seizures, frequency:			

17a. Diabetes? If yes, Type:	☐	☐	
17b. Is youth insulin dependent?	☐	☐	
18. Does child receive in-home specialized nursing care?	☐	☐	
19. Other medical conditions requiring assistance: LIST BELOW IN COMMENTS. Comments:			

BEHAVIORAL RISKS	YES	NO	COMMENTS
Behaviors (Directed at Self)			**Include frequency and triggers**
1. Biting/hitting oneself severely	☐	☐	
2. Head banging	☐	☐	
3. Inserting harmful objects into body orifices	☐	☐	
4. Skin picking or severe scratching	☐	☐	
5. Pica/consumption of non-edibles	☐	☐	
6. Other:	☐	☐	
Behaviors (Directed at Others)			**Include frequency, triggers, and which individuals are targeted (i.e., parent, sibling, teacher, strangers)**
7. Hitting, biting, or kicking others	☐	☐	
8. Making direct threats of violence	☐	☐	
9. Explosive anger/aggression	☐	☐	
10. Severe defiance/consistent refusal or noncompliance with directions	☐	☐	

OTHER BEHAVIORS	YES	NO	If Yes, describe what treatment/services child is receiving, if any
11. Substance use	☐	☐	
12. Criminal legal involvement	☐	☐	
13. Problem sexual behavior	☐	☐	
14. Impulsive running off	☐	☐	
15. Frequent wandering away	☐	☐	
16. Unusual climbing behaviors	☐	☐	
17. Property damage	☐	☐	
18. Fire setting	☐	☐	
19. Other:	☐	☐	

TRAUMA AND RISK CONDITIONS	YES	NO	Comments
1. History of physical abuse	☐	☐	
2. History of sexual abuse	☐	☐	
3. History of being bullied	☐	☐	
4. History of serious losses such as death of a sibling or parent	☐	☐	
5. History of removal from home due to abuse or neglect	☐	☐	
Mental Health Concerns	**YES**	**NO**	**If Yes, describe what treatment/services child is receiving, if any**
6. Depression (hopelessness, sadness, mood swings)	☐	☐	
7. Anxiety (excessive worry, panic attacks)	☐	☐	
8. Attention Deficit Hyperactivity Disorder	☐	☐	
9. Severe mood swings and/or irritability	☐	☐	
10. Tics, movement disorder	☐	☐	
11. Seeing or hearing things that are not real, paranoid	☐	☐	
Comments:			

SECTION IV: SUPERVISION NEEDS AND USE OF ADAPTIVE EQUIPMENT

Remember to rate the child's average functioning or use of equipment within the **last 6 months**. You may indicate in the comment boxes any additional information such as and whether the child's current abilities or need for adaptive equipment have improved or gotten worse compared to past abilities.

SUPERVISION NEEDS IN THE HOME	YES	NO
1. Requires age-appropriate supervision	☐	☐
2. 24-hour awake supervision day and night	☐	☐
3. Close supervision during day	☐	☐
4. Daily on-site support/supervision, limited hours	☐	☐
5. Can identify an emergency and get help for self	☐	☐
6. Requires assistance to evacuate home	☐	☐

SUPERVISION NEEDS IN THE COMMUNITY	YES	NO
1. Requires age-appropriate supervision	☐	☐
2. 24-hour awake supervision day and night	☐	☐
3. Close supervision during day	☐	☐
4. Can be left alone in specific places	☐	☐
5. Travels in community independently	☐	☐
6. Vulnerable to exploitation	☐	☐

Comments:

USES OF ADAPTIVE EQUIPMENT	CHECK IF USES	Comments			
Wheelchair (You may select more than one)	☐	☐ Manual	☐ Motorized	☐ Self-Propels	☐ Requires Assistance
Helmet	☐				
Eyeglasses	☐				
Walker/crutches/cane	☐				
Modified eating utensils	☐				
PERS — Personal Emergency Response System	☐				
Corrective shoes/braces	☐				
Hearing aid	☐				
Augmentative communication device	☐				

USES OF ADAPTIVE EQUIPMENT	CHECK IF USES	Comments
Other: Please Describe	☐	
1		
2		
3		
Comments:		

USES OF ENVIRONMENTAL MODIFICATIONS	CHECK IF USES	Comments
Wheelchair-accessible vehicle	☐	
Accessible bathroom facilities	☐	
Ramp	☐	
Lifts: porch, hoyer, stair	☐	
Other: Please describe	☐	
1		
2		
3		
Comments:		

Discrimination is against the law

PerformCare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PerformCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PerformCare reduces language barriers to accessing services through the New Jersey Children's System of Care by:

- Providing free aids and services to people with disabilities to communicate effectively with us, such as:
    - Written information in other formats (large print, audio, accessible electronic formats, and other formats).
    - Telecommunication devices such as Device for the Deaf (TDD) and Text Telephone (TTY) systems to enable individuals who are deaf, hard of hearing, or speech-impaired to use the phone to communicate.
- Providing language services at no cost to people whose primary language is not English, such as:
    - Qualified interpreter services.
    - Information written in other languages.

If you need these services, contact PerformCare at **1-877-652-7624** or [**TTY** (for the hearing impaired) **1-866-896-6975**]. We are available 24 hours a day, seven days a week.

If you believe that PerformCare 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 submit a complaint by mail or phone, by either calling PerformCare's Quality department at **1-877-652-7624** or by writing to:

PerformCare
Attn: Quality Department
300 Horizon Center Drive, Suite 306, Robbinsville, NJ 08691

If you need help filing a complaint, PerformCare's Quality department is available to help you.

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**.

Multi-language interpreter services

Attention: If you do not speak English, language assistance services are available to you at no cost. Call 1-877-652-7624 (TTY 1-866-896-6975).

Spanish: Atención: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-652-7624 (TTY 1-866-896-6975).

Portuguese: Atenção: Se fala português, encontra-se disponível serviço gratuito de intérprete pelo telefone 1-877-652-7624 (TTY 1-866-896-6975).

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-652-7624 (رقم هاتف الصم والبكم: 1-866-896-6975 :TTY).

Haitian Creole: Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-652-7624 (TTY: 1-866-896-6975).

Chinese Mandarin: 注意：如果您说中文普通话/国语，我们可为您提供免费语言援助服务。请致电：**1-877-652-7624 (TTY 1-866-896-6975)**。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-652-7624 (TTY 1-866-896-6975)** 번으로 전화해 주십시오.

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১**1-877-652-7624 (TTY 1-866-896-6975)**।

French: Attention : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-652-7624 (TTY 1-866-896-6975).

Vietnamese: Chú ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-652-7624 (TTY 1-866-896-6975).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-877-652-7624 (TTY 1-866-896-6975)** पर कॉल करें।

Chinese Cantonese: 注意：如果您使用粵語，您可以免費獲得語言援助服務。請致電 **1-877-652-7624 (TTY 1-866-896-6975)**。

Polish: Uwaga: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-652-7624 (TTY 1-866-896-6975).

Urdu:
توجہ فرمائیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں 1-877-652-7624 (TTY: 1-866-896-6975).

Turkish: Dikkat: Türkçe konuşuyorsanız dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-877-652-7624 (TTY 1-866-896-6975) numaralı telefonu arayın.

Russian: Внимание: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-652-7624 (TTY 1-866-896-6975).