Clear Form

Minnesota Department of **Human Services**

DHS-6532-ENG 6-16

***Consumer Directed Community Supports (CDCS)***

# Community Support Plan - Rule 185 Compliant

This plan covers the time period from: **2/1/2020** to: **10/31/2020** Annual budget amount: **$41,607.73**

(•) New ( ) Renewal ( ) Revision

## Person Receiving Services

| NAME | DATE OF BIRTH | PMI NUMBER | MEDICARE, PRIVATE OR OTHER INSURANCE NUMBER (if applicable) |
|---|---|---|---|
| Walid El Haidari | 12/19/1973 | 03627093 | N/A |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| 12438B Flanders Ct NE | Blaine | MN | 55449 |

| EMAIL ADDRESS | PREFERRED PHONE NUMBER | COUNTY OF RESIDENCE | COUNTY OF FINANCIAL RESPONSIBILITY (CFR) |
|---|---|---|---|
| hiba_7ala@hotmail.com | 507-351-5079 | Anoka | Anoka |

WAIVER TYPE

( ) AC ( ) BI-NB ( ) BI-NF ( ) CAC (•) CADI ( ) DD ( ) EW ( ) Prepaid Health Plan

## Parent/Legal Representative/Managing Party (if any)

| NAME | EMAIL ADDRESS | HOME PHONE NUMBER | CELL PHONE NUMBER |
|---|---|---|---|
| Hiba Matar | hiba_7ala@hotmail.com | | 507-351-5079 |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| 12438B Flanders Ct NE | | MN | 55449 |

***Add person***

## Lead Agency/County Representative/Care Manager

| NAME |
|---|
| Thomas Allen Inc. |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| 9298 Central Ave NE Suite 222 | Blaine | MN | 55434 |

| CONTACT NAME | EMAIL ADDRESS | PHONE NUMBER | FAX NUMBER |
|---|---|---|---|
| William Doyle | william.doyle@thomasalleninc.com | 651-444-5423 | 888-501-0982 |

## Fiscal Support Entity (FSE) (person or agency that bills and reimburses)

| NAME |
|---|
| Accra |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| 12600 Whitewater Drive, Suite 100 | Minnetonka | MN | 55343 |

| CONTACT NAME | EMAIL ADDRESS | PHONE NUMBER | FAX NUMBER |
|---|---|---|---|
| Heather Ofstehage | HeatherOfstehage@accracare.org | 952-356-1403 | 952-935-7112 |

## Support Planner (if any)

| NAME | | | |
|---|---|---|---|
| Beyle Support Planner | | | |
| ADDRESS | CITY | STATE | ZIP CODE |
| 3030 France Ave South Suite 328 | Minneapolis | MN | 55416 |
| CONTACT NAME | EMAIL ADDRESS | PHONE NUMBER | FAX NUMBER |
| Liben Ahmed | lamad93@gmail.com | 612-986-4144 | |

## Employment Model

If you don't know, contact your FSE.

- ○ Agency with Choice
- ◉ Payroll Model
- ○ Fiscal Conduit

## Additional Contacts

Individuals or agencies who provide paid or unpaid supports to help you meet your goals.

| **DOCTOR NAME** | CLINIC | PHONE NUMBER | EXT. |
|---|---|---|---|
| Dr. John Scheaffhousen | Voyage Clinic | 763-494-7500 | |
| ADDRESS | CITY | STATE | ZIP CODE |
| 9825 Hospital Dr #300 | Maple Grove | MN | 55639 |

| **HOSPITAL NAME** | | PHONE NUMBER | EXT. |
|---|---|---|---|
| Voyage Healthcare - Maple Grove | | 763-494-7500 | |
| ADDRESS | CITY | STATE | ZIP CODE |
| 9825 Hospital Dr #300 | Maple Grove | MN | 55639 |

| **SCHOOL NAME** | | PHONE NUMBER | EXT. |
|---|---|---|---|
| | | | |
| ADDRESS | CITY | STATE | ZIP CODE |
| | | MN | |

| **NAME** | | PHONE NUMBER | EXT. |
|---|---|---|---|
| Mental Health Nurse Practitioner at Open Door Health | | 507-388-2120 | |
| ADDRESS | CITY | STATE | ZIP CODE |
| 309 Holly Lane | Mankato | MN | 56001 |

***Add contact***

# Evaluation of Last Year's Plan

Complete this section only if you are renewing your plan. This section is to help you evaluate last year's plan and to begin planning for this year's plan. List the goals from your last CDCS Plan.

| **Goal** |
|---|
| **What did you do?**<br>This is the first year. Evaluations will be completed next year. |

**What was changed or improved?** (check all that apply)

- ☐ Greater independence
- ☐ More community activities
- ☐ Skill development and/or skill maintenance
- ☐ Personal development
- ☐ Maintain health and safety
- ☐ Maintain living in the best place for me

**Do you plan to work on this goal in next year's plan?**

- ◯ Yes, in the same way as we did last year
- ◯ Yes, with changes
- ◯ No, this is no longer an area of concern or need

***Add goal***

**Were there any services or supports you needed that were not available?**

N/A

# Plan

## Describe yourself

When developing your Annual Community Support Plan it's important to tell us about yourself by describing your strengths and needs, likes and dislikes, and how your disability or condition impacts your life. Some people find these questions easy to answer and can do so without assistance. Others have found it helpful to participate in a facilitated person-centered planning process. Information about person-centered planning processes can be found in the DHS CDCS Consumer Handbook, Appendix H.

Remember, all goods and services must be directly related to the disability and/or condition and based on the goals you detail in this Community Support Plan.

STRENGTHS

Cooperative most of the time
Very strong
Loving

NEEDS

Walid needs to be physically fed by someone else. Walid needs total assistance with bathing such as shampooing his hair, transferring in/out and washing his body. Walid needs assistance with dressing his upper and lower body, buttons and putting his socks and shoes on.
Walid needs to be cued to use the bathroom, help transferring on/off the toilet and peri-cares. He has occasional accidents. Walid is able stand but uses a wheelchair to move around his home and community. He needs assistance with stairs. Walid needs assistance to re-position himself at his request if he is in a lot of pain. He needs assistance with transferring until he is steady on a daily basis.

LIKES

Walid's interests depend on how he is feeling on a particular day
On a good day, Walid enjoys watching TV or taking car rides with his family
On a bad day, Walid tends to prefer being alone and does not participate in activities - on such days, he is content with sleeping as much as possible

DISLIKES

Walid struggles to control his emotions

DESCRIBE YOUR DISABILITY OR HEALTH CONDITION AND HOW IT IMPACTS YOUR LIFE

Walid's mental health and physical health diagnoses seriously affect his life. He does not appear to enjoy things that most people enjoy, and when he is having a bad day - he tends to sleep as much as possible. Walid is unable to complete any of his personal cares independently, requiring assistance with personal hygiene including toilet use, grooming and showering. Whats more, he is unable to prepare any of his food, requiring assistance with both preparing food and feeding by others. Walid is unable to function independently for prolonged periods of time.

Cognitively, Walid's wife reports that he experiences difficulties with regulating his emotions, and tends to withdraw from family. He is reported to get agitated easily when he does not get what he wants immediately. He also experiences hallucinations and flashbacks related to the trauma he has endured during his childhood. He appears to be experiencing moderately severe depression.

Walid is unable to look after his finances or meet his financial responsibilities, nor is he able to direct his own cares. Due to these challenges related to his diagnoses, Walid requires extensive assistance on a daily basis in order to maintain his health status.

**********A detailed health and safety plan is included**********

LIST YOUR DIAGNOSIS/CONDITIONS

Major Depression;
recurrent, Generalized
Anxiety Disorder, Post-
traumatic stress disorder
High cholesterol
High blood pressure
Muscle pain, lower back pain, and neck pain
Muscle weakness
Fatigue
Lumbar Radiculopathy Due to Osteoarthritis Irritable Bowel Syndrome with Constipation Gastritis, Esophageal Reflux
Atypical chest pain
Dementia without Behavioral disturbances

## A. Personal Assistance

Identify and explain what supports, services or goods you would like to use to accomplish your goals. *Examples:* support for personal care, caregiver relief, paid parent of a minor or spouse.

**Personal Assistance:** Caregiver assistance, paying parents/spouse, assistance with ADLs

| | Type of service (and who is being paid) | Rate of pay or cost | # of hours/units per week/ month/year | # of weeks/ months | *Does PTO apply? | *Do payroll taxes apply? | Total | |
|---|---|---|---|---|---|---|---|---|
| 1. | Staff Mohamed Elhaidari | $17.25 | 26 | 39 | Yes ○No | Yes ○No | $17,491.50 | × |
| 2. | Staff Mustapha Elhaidari | $17.25 | 25 | 39 | Yes ○No | ○Yes No | $16,818.75 | × |
| | *Add service* | | | | | Grand Total | $34,310.25 | |

***Contact your FSE to help determine if paid time off (PTO) and payroll taxes apply for this service (most positions require PTO and payroll taxes).**

### What are your goals and outcomes?

**Goal 1.**

Describe (include how to implement and measure results)

Long term: Walid will live in a least restrictive environment

Short term: Walid will access person centered support services to avoid institutionalization

Walid's family wishes for him to be able to remain in his home, and be supported by his family and community who understand his culture and belief system. To achieve this goal, Walid's wife will help with identifying, recruiting and training of staff to support Walid along the lines of his assessed needs. Support needed includes, but is not limited to: assistance with bathing and shampooing his hair, transferring in/out of shower, dressing his upper and lower body, buttons and putting his socks and shoes on. Staff will help with all other personal hygiene/grooming tasks such as combing his hair, brushing his teeth, shaving, nailcares and peri-cares are completed for him by another. Walid needs to be cued to use the bathroom, help transferring on/off the toilet and peri-cares.

Success will be measured by Walid's ability to maintain proper hygiene and remain in his family home instead of requiring institutional care to meet his daily needs

**Goal 2.**

Describe (include how to implement and measure results)

Long term: Walid will maintain stable mental health without institutionalization

Short term: Walid will seek mental health treatment and maintain compliance with treatment

Walid's staff will provide ongoing support towards stability by assisting with making sure his is taking his medication as prescribed and motivate him to follow medical provider's recommendations. Walid requires multiple medications on a daily basis, and he relies on help from his staff and family members to manage his medications for him. He, Walid, does not read or speak English, and does not know what his medications are, what they are for, the dosage, or side effects. Staff and other family members will assist with making follow up appointments, transporting to and from appointments as needed, as part of the support he needs to achieve mental health stability. Staff will also keep track of Walid's progress, and help him report the feedback to his medical providers as needed.

Success will be measured by Walid's success in maintaining compliance with his treatment regimens. The goal is 100% compliance with treatment, and 100% attendance at appointments.

***Add goal***

I would like the agency/person responsible for providing this service to have the following qualities, skills or training (if applicable)

Walid needs his staff to be familiar with him, know his likes and dislikes, as well as the best ways to help him have more good days than bad. At this time, his family members and family friends are the best people to support him.
If the need arises for Walid to work with someone outside his network, his wife will assist with hiring, and providing the necessary training and orientation before said staff work with him. This will include all staff gaining a good understanding of his assessed needs and diagnoses, and the cultural dynamics and trauma informed care plan that he requires to remain at home despite his diagnoses.

I need these services because: (Give rationale to items that are typically seen as participant/family responsibility.)

Walid's health is described as "poor", requiring ongoing support to maintain and work on improving his current status. Walid sees his primary doctor at least annually and as needed, and in the past year alone, he was seen at an Emergency Room on 3 separate occassions. Due to the severity of his diagnoses, Walid is completely dependent on his staff and family members to support him. Walid's diagnoses have left him unable to attend to his basic needs, and he therefore requires mental health support, and ongoing support with all activities of daily living in order to manage the debilitating symptoms of his mental health diagnoses. Without said support he will need institutionalization.

**Do you plan to use a paid parent of minor or spouse as staff?** ◯ Yes ◉ No

## B. Treatment and Training

Identify and explain what supports, services or goods you would like to use to accomplish your goals. *Examples:* Specialized health care, Habilitative Services, Vocational/work services, Training and Education, etc.

**Treatment and Training:** Nursing, Habilitative service, DT&H, training, therapies

| | Type of service (and who is being paid) | Rate of pay or cost | # of hours/units per week/ month/year | # of weeks/ months | *Does PTO apply? | *Do payroll taxes apply? | Total |
|---|---|---|---|---|---|---|---|
| 1. | Natural Supports (unpaid staff) | $0.00 | 0 | 0 | ◯Yes No | ◯Yes No | $0.00 |

***Note: DD Waivers require a habilitative component in the Community Support Plan. Goals and outcomes should be measurable and observable for DD Waiver plans.**

**What are your goals and outcomes?**

**Goal 3.**

Describe (include how to implement and measure results)

Walid will improve his independence

Walid will work on maintaining and improving life skills as he is able

Walid receives natural supports from his wife, Hiba. She provides ongoing skills development. Hiba acts as Walid's primary caregiver, and she also motivates him to maintain independence as much as he is able. Hiba will continue this role, working more deliberately to help Walid avoid incontinence and relearn to control this bodily function as much as he can. Hiba trains Walid through modeling, and motivates him to participate in different learning opportunities

Success will be measured by Walid's ongoing participation in his cares as much as he is able.

***Add goal***

I would like the agency/person responsible for providing this service to have the following qualities, skills or training (if applicable)

It is important for Walid to receive ongoing support above and beyond what his staff provide, and for this he relies on his wife - Hiba. Hiba plans to continue this role, even as she would also be a paid staff for Walid.

I need these services because: (Give rationale to items that are typically seen as participant/family responsibility.)

Walid's poor health and described above, necessitates support beyond what people his age and paid staff can provide. The natural supports will be provided by his wife Hiba, and Walid will also seek additional professional treatments if the need arises. All of these are critical to his continued desire to reside with his family, while maintaning health and safety with the least level of restricts that his condition allows.

**Does your budget amount include the additional funds (20% increase) for individualized employment supports or services during the day?** ◯ Yes ◉ No

## C. Environmental Modifications and Provisions

Identify and explain what supports, services or goods you would like to use to accomplish your goals. *Examples:* Transportation, assistive technology, home/vehicle modifications, environmental supports, services, supplies, special diets that are prescribed, etc.

**Environmental Modifications and Provisions:** Assistive technology, modifications, special diets, equipment, transportation

| | Type of service/support (and who is being paid) | Cost | Quantity | # of weeks/ months | Total |
|---|---|---|---|---|---|
| 1. | | | | | |
| | *Add service/support* | | | **Grand Total** | |

**What are your goals and outcomes and/or rational for services/supports?**

| **Goal** |
|---|
| Describe (include how to implement and measure results) |

*Add goal*

| |
|---|
| I would like the agency/person responsible for providing this service to have the following qualities, skills or training (if applicable) |
| I need these services because: (Give rationale to items that are typically seen as participant/family responsibility.) |

## D. Self-Direction Support Activities

Identify and explain what supports, services or goods you would like to use to accomplish your goals. *Examples:* support planner, payroll costs, newspaper ads, etc.

**Self-Direction Support Activities:** Support Planner, FSE fees, payroll expenses

| | Type of service (and who is being paid) | Rate of pay or cost | # of hours/units per week/month/year | # of weeks/ months | Total |
|---|---|---|---|---|---|
| 1. | Accra fee | $140.00 | 1 | 9 | $1,260.00 |
| 2. | Beyle Support Planner | $50.00 | 9 | 1.67 | $750.00 |
| | Payroll Taxes | PERCENTAGE OF PAYROLL TAXES 1.20% | PAYROLL WAGES $17,491.50 | | $209.90 |
| | Paid Time Off (PTO) | PERCENTAGE OF PTO 3.10% | PTO WAGES $34,310.25 | | $1,063.62 |
| | *Add service* | | | **Grand Total** | **$3,283.51** |

- Support Planners must be certified with the MN Department of Human Services (DHS).
- Fiscal Support Entities must be enrolled with DHS and complete a "Readiness Review" as well as ongoing reviews by DHS.

List other or unique qualifications desired (if any)

*The Support Planner will be certified and maintain status of the position and continue with ongoing SP training that the state and the county require. The SP will also maintain person-centered planning training.

*The Financial Management Services will maintain its FMS requirements and will attend required county and state

trainings and meetings to maintain their FMS status.

# Annual Budget Plan

Annual budget amount: **$41,607.73** Budget covers plan period from: **2/1/2020** to: **10/31/2020**

***Reminder: CDCS is a prorated budget.**

## MA Home Care Services

Services provided by a Homecare Agency include Personal Care Attendant (PCA), Skilled Nursing, Home Health Aide, and Private Duty Nursing. They must be listed separately and billed directly to DHS (or managed care entity if applicable) by the homecare agency. These services are not billed through the Fiscal Support Entity. Only units of PCA must be split into six month unit amounts.

### Personal Care Attendant (PCA)

| PROVIDER/PROVIDER NUMBER | RATE PER UNIT OR VISIT | NUMBER OF HOURS/UNITS PER WEEK | NUMBER OF WEEKS | TOTAL COST TO PLAN |
|---|---|---|---|---|
| UNITS FOR FIRST 6 MONTHS OF PLAN | UNITS FOR LAST 6 MONTHS OF PLAN | | UNITS OF PCA SUPERVISION | |
| ***Add provider*** | | | **Total Cost** | |

### Nursing Services (Private duty nursing, skilled nursing visits, home health aide)

| PROVIDER/PROVIDER NUMBER | RATE PER UNIT OR VISIT | NUMBER OF HOURS/UNITS PER WEEK | NUMBER OF WEEKS | TOTAL COST TO PLAN |
|---|---|---|---|---|
| ***Add provider*** | | | **Total Cost** | |

**MA Home Care Services Total**

## Annual Budget **$41,607.73**

| | |
|---|---|
| Total Personal Assistance | $34,310.25 |
| Total Treatment and Training | $0.00 |
| Total Environmental Modifications | |
| Total Self-Directed Support Activities | $3,283.51 |
| Total MA Home Care Services | |
| **Grand Total** | **$37,593.76** |
| **Unused Budget Amount** | **$4,013.97** |

# Monitoring

Your Community Support Plan must include who (paid and unpaid) is responsible for monitoring.

| Who will monitor *health and safety* along with lead agency/care manager? | How often? |
|---|---|
| Hiba Matar (spouse) | ◯ Monthly ◯ Quarterly ◉ Other<br>Specify other: daily, or as needed |

***Add health/safety monitor***

| Who will monitor *expenditures* along with lead agency/care manager? | How often? |
|---|---|
| Hiba Matar (spouse) | ◯ Monthly ◯ Quarterly ◉ Other<br>Specify other: as needed |
| Fiscal Support Entity Staff | ◯ Monthly ◯ As needed, at least monthly |

***Add expenditures monitor***

**Who will be responsible for assuring the provider qualifications and training of the support people**

☐ Person using ☐ Licensed ☒ Parent/Responsible ☐ PCA
☐ CDCS ☐ Agency

# Health and Safety Plan

DATE 1/20/2020

(You may attach a copy of a completed risk management plan as your health and safety plan.)

How will you meet your health and safety needs? Think about what supports and services are needed along with what skills and knowledge staff may need. Revise the plan as necessary to meet your individual needs. **Detail is important**

Please see attached health and safety plan

**here!** Highlight how all health and safety issues will be met.

# What will I do in case...

What will you do in case there is an emergency? What if staff does not show up for a shift, the primary caregiver has a sudden illness, or staff is late for a shift? The guide includes questions to help you think about your emergency plan.

(Complete this emergency plan and update as necessary.)

| DATE 1/20/2020 | Who do you call? | Alternate person |
|---|---|---|
| **NAME** | Hiba Matar | |
| **PHONE** | 507-351-5079 | |

## Participation Agreement

I understand that participating in Consumer-Directed Community Support Services (CDCS) means I have the authority and flexibility to plan and spend funds within my allocated budget and according to the Minnesota Department of Human services policies. I also understand and agree to my responsibilities as stated below.

### Parent of minor/spouse pay responsibilities

- I will not work more hours than are approved in my plan. **(Parents of minors or spouse may not work more then 40 hours per week.)**

### Participant responsibilities

- I am responsible to develop an annual CDCS Community Support Plan using a person centered planning process that:
  - Is focused on my needs, preferences, talents, abilities, choices and vision for my future
  - Involved me and/or my parent (if I am a minor child or guardian) and other people who are important to me
  - Is built on my capacity to participate in activities that promote community life.
- Risks that pose harm to me have been identified, assessed and were addressed in the plan.
- I have assured all supports, services and goods purchased through this plan are necessary due to my disability.
- I have assured all supports, services and goods purchased through this plan are the least costly and effective means to meet my needs.
- I am responsible for submitting the annual CDCS Community Support Plan on time and by the due date designated by the assigned case manager or care coordinator to avoid a lapse of services.
- I am responsible to decide who will arrange for the supports and items identified in my plan.
- I understand I can only purchase supports and items identified in my approved plan.
- I understand my budget can only be spent in the time period stated in my plan and expenditures can not exceed the approved amount.
- I am responsible to arrange for the timely payment of all approved services, supports and goods.
- I understand that I am responsible for expenditures that are not approved in my plan. The lead agency will not be responsible for such expenditures.
- I understand that I am responsible for expenditures that are in excess of the expenditures approved in my plan. The lead agency will not be responsible for such expenditures.
- I understand that as a condition of being on a waiver program or the Alternative Care program, I (waiver participant) must participate in an annual face-to-face reassessment.
- I understand my case manager or care coordinator must have a minimum of two face-to-face visits with me within a twelve- month period.
- I understand that the annually approved plan remains in effect unless and until the lead agency approves any requested changes.
- I understand that no changes or revisions can be made to the CDCS Community Support Plan and/or CDCS budget during the last **30 days** of the plan yeaurn, less approved by the assigned case manager or care coordinator for reasons of critical health and safety.
- I understand that I must develop a job description and work schedule if I am being paid as a parent of a minor or spouse.
- I understand that income earned for being a support worker may affect my eligibility for other income based assistance programs.
- I assume full responsibility for my choices of people to provide unlicensed support. I understand that they are not employees of the lead agency and I will not hold the lead agency and/or its employees responsible for any act or omission on the part of the person providing unlicensed support.
- **I understand that I must notify my case manager or care coordinator whenever I (the person using CDCS) am hospitalized or enter a nursing home or mental health facility. I understand that CDCS services may not be billed and will not be reimbursed during that time.**
- I understand that I am responsible for maintaining my eligibility for the program (Medical Assistance [MA], waiver or the Alternative Care program).
- I understand I must have documentation that verifies all supports provided and items purchased. Falsified documentation will result in termination of the CDCS option.
- I understand that if I do not adhere to the responsibilities identified in this participation agreement, one or more of the following actions may result:
  - Recommended use of a support planner who will be paid from my CDCS budget
  - Return of funds not used according to program guidelines
  - Termination from CDCS and return to traditional services
  - Prosecution for Medicaid fraud
- I understand that I must cooperate with any investigation the State of Minnesota and/or the lead agency initiates regarding misuse of funds.
- I have been informed of my appeal rights and I understand I have the right to request a conciliation conference or an appeal hearing to address service delivery concerns. (Minn. Stat. §256.045)
- I understand that my annual state-set CDCS budget amount is based on the results of my assessment.
- I received a copy of the lead agency/county responsibilities under CDCS.
- I received a copy of the lead agency's data privacy practices, which explains my right to confidentiality.
- I was offered a choice of providers.
- I was offered a choice of services.
- I participated in the development of this support plan.
- I was offered a choice between receiving services in the community or a nursing home.

**I have reviewed the Consumer-Directed Community Supports (CDCS) Services participation agreement above with my lead agency representative and I understand my responsibilities under this service option.**

## Signatures

| RECIPIENT | DATE |
|---|---|
| | |

| PARENT/LEGAL REPRESENTATIVE/MANAGING PARTY | DATE |
|---|---|
| | |

**Lead Agency Representative/ Care Manager Completes:**

☐ This plan includes a habilitative component (required for DD Waiver only) ☐ Health, Safety and Emergency Plan have been reviewed

☐ This plan and budget is approved.

| LEAD AGENCY REPRESENTATIVE/CARE MANAGER | DATE |
|---|---|
| | |

| LEAD AGENCY REPRESENTATIVE/CARE MANAGER | DATE |
|---|---|
| | |

**Print Form**

## 651-431-2493 or 800-627-3848

Attention. If you need free help interpreting this document, call the above number.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

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LB3-0001 (3-13)

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