Cheyenne County HOSPITAL

"Improving Health through Access to Quality Care"

NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices is effective as of 3/01/2023

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH INFORMATION -- HOW IT IS USED AND HOW IT MAY BE SHARED WITH OTHERS: There are laws requiring that we maintain the privacy and security of your health information. They tell us how we may use and disclose health information. Those laws also require that we make a copy of this Notice available to you. This Notice describes how we use and disclose your health information, and your rights pertaining to that information.

WHAT IF YOU HAVE QUESTIONS ABOUT THIS NOTICE OR NEED TO EXERCISE YOUR RIGHTS? If you do not understand this Notice or what it says about how we may use your health information, or would like to exercise any of your rights set forth below, please contact:

The Privacy Officer
Cheyenne County Hospital
PO Box 547
St. Francis, KS 67756 785-332-2104

WHAT IS YOUR HEALTH RECORD OR HEALTH INFORMATION? When you go to a hospital, doctor, or other health care provider, a record is made that documents your treatment. This record will have information about your illnesses, your injuries, signs of illness, exams, laboratory results, treatment given to you, and notes about what might need to be done at a later date. Your health information could contain all kinds of information about your health problems. The Facility keeps this health information and can use this information in many ways. What we do with your health information and how we can use and share this information is what the rest of this Notice describes.

YOUR RIGHTS. When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

*__Get an Electronic or Paper Copy of Your Medical Record__. You have the right to inspect and obtain a paper or electronic copy of your medical record and other health information we have about you. Ask us how to do this. Generally, if you want to see your health information and/or get a copy of your health information, you must make a request to the Contact Person in writing. However, alternative arrangements may be made for individuals unable to make a request in writing. You may request that your information be provided in an electronic format and we will provide the information to you in the form and format you request, if it is readily producible. If we cannot readily produce the records in the form and format you request, we can work together to agree on an appropriate electronic format. You may also direct us to transmit your health information in paper or electronic format to a third party. If you direct us to transmit your information to a third party, we will do so, provided your signed, written direction clearly identifies the designated third party and where to send the information. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. We may deny your request to inspect or obtain a copy in

certain limited circumstances. If we refuse access, we will tell you in writing within 30 days of your request, and in some circumstances, you may ask that a neutral person review the refusal.

*__Ask Us to Correct Your Medical Record__. You can ask us to correct health information about you that you think is incorrect or incomplete for as long as we have it. If you want to make a change to your health information, you must give a good reason for the change. If you do not put your request for a change in writing and give a good reason, we may not allow the change to be made. We may also refuse your request for change for the following reasons: (1) the information was not created by this Facility; (2) it is not a part of the health information kept by or for the Facility; (3) it is not information you are permitted to see or copy; or (4) it is accurate and complete. If we say "no" to your request, we'll tell you why in writing within 60 days.

*__Get a List of Those With Whom We've Shared Information__. You can ask for a list (accounting) of the times we've shared your health information for 6 years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (for example, any disclosures you asked us to make). To request a list, you must write a request to the Facility. You have to include a time period in your request. We only need to provide this information for specified time periods. You should tell us in what form you want the list (paper copy, electronically, or some other form). You can have one list each year at no cost. You may be charged a reasonable, cost-based fee for any additional lists requested within 12 months.

*__Ask Us to Limit What We Use or Share__. You have the right to ask that we restrict or limit some part of your health information. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. *You must be aware that when your request for restriction has not been made prior to submission of the Facility's payment request to the third party payer, it may not be possible to facilitate the requested restriction. If you wish to restrict the submission of health information to your third party payer, you should make that request prior to the commencement of treatment.* All requests for restriction should be directed in writing to the Contact Person. We will notify you in writing within 30 days as to whether your request is granted or denied.

*__Request Confidential Communications__. You have the right to ask that we communicate with you about your health information only in a certain way or at a certain location. An example would be asking that you only be contacted by us at work or only by mail, or you may prefer that we communicate with you via unencrypted email or text messaging. There are risks associated with communications via unencrypted email or text messaging, for example, a third party could intercept the email or text message in transmission. To ask for privacy in communications, you must make your request in writing to the Facility. We will attempt to grant all reasonable requests and although you are not required to give reasons for your request, we may ask you. Be sure to be specific in your request about how and where you wish to be contacted.

*__Receive Notice if Your Health Information is Breached__. A "breach" occurs when your health information is acquired, assessed, used, or disclosed in a manner not permitted by HIPAA which compromises the privacy or security of your information. Not all types of breaches require notice, but if notice is required, we will provide such notification without unreasonable delay, but in no case, later than 60 days after we discover the breach.

*__Get a Copy of This Privacy Notice__. A copy of this Notice is available to you at your request and you have a right to a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you may request a paper copy of it. We will provide you with a paper copy promptly. You may also obtain a copy of the Notice at our web site, www.cheyennecountyhospital.com

*__Choose Someone to Act for You__. If you have given someone a durable health care power of attorney that is currently in effect or if someone is your legal guardian, that person may exercise your rights and make choices

about your health information. We will make sure the person has this authority and can act for you before we take any action.

***File a Complaint If You Feel Your Rights Are Violated.** You can file a complaint if you feel we have violated your rights by contacting us using the contact information on Page 1. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

OUR USES AND DISCLOSURES. We typically use or share your health information in the following ways:

***For Treatment.** We may use your health information to provide you with medical treatment or services. We may give your health information to other doctors, nurses, technicians, medical students, or other staff personnel who are involved in taking care of you. For example, a doctor treating you for a broken bone may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for meals. Different departments of the Facility may share your health information in order to coordinate the different services you need, such as prescriptions, lab work, and x-rays. The Facility may also request information from your health care providers outside the Facility to assist with your care. For example, we may request and use your prescription medication history from other health care providers or third party pharmacy benefit payers for treatment purposes. We also may provide access to and/or disclose your health information to health care providers outside the Facility who may be involved in your treatment while you are in the Facility or after you leave the Facility.

***For Payment.** We may use and disclose your health information about the treatment you receive in the Facility to bill and get payment from individuals, health plans, or other entities. For example, we may give information to your health insurance plan information about your surgery so that your plan will pay for your services. We may have to give information to your health plan before your surgery in order to get an authorization so your plan will pay for the surgery. However, if you pay out of pocket for your treatment and make a specific request that we not send information to your health plan, we will not send that information to your insurance plan except under certain circumstances. We may also use and disclose your health information to obtain payment from third parties that may be responsible for the costs of your treatment, such as family members.

***For Health Care Operations.** We may use and disclose your health information to operate the Facility, improve your care, and contact you when necessary. For example, we may use your health information to see how well our staff takes care of you. We may combine your health information with other patients' information to decide on additional services we should offer to our patients and to see if new treatments really work. We may remove information from your health information so others who look at your health information cannot see your name. Here are some other examples of how we may use and disclose your health information for our health care operations: to see how well we are doing in helping our patients (including investigation of complaints); to help reduce health care costs; to develop questionnaires and surveys; to help with care management; for training purposes; and to conduct cost management and business planning activities and certain marketing and research activities. We may disclose your health information to other health care providers and entities to assist in their health care operations under certain circumstances.

> ***For Contact Information.** We may use and disclose your contact information (landline or cellular phone numbers, email address). Some examples of how we may use your contact information include appointment reminders and to provide you with notification of other health-related benefits and services, all of which are discussed in more detail below. By providing us with your contact information, you give your consent that we may use it. We may contact you by the following means (even if we initiate contact using an automated telephone dialing system (ATDS) and/or an artificial or prerecorded voice): (1) paging system; (2) cellular telephone service; (3) landline; (4) text message; (5) email message; or (6)

facsimile. If you want to limit these communications to a specific telephone number or numbers, you need to request that only a designated number or numbers be used for these purposes. If you inform us that you do not want to receive such communications, we will stop sending these communications to you.

*__Business Associates.__ We may disclose your health information to our contracted business associates in order to carry out specific tasks related to the Facility's health care operations. When we do this, the business associate agrees in the contract to protect your health information and to use and disclose such health information only to the extent the Facility would be able to do so.

*__Appointment Reminders; Telephone and Email Messages__. We may use and disclose your health information to contact you and remind you of an appointment at our Facility. This may include contacting you with the date, time, and location of your appointment by (1) sending a reminder card to the most recent mailing address we have for you; (2) sending an email message to the most recent email address we have for you if you have requested we communicate by email; (3) calling the most recent telephone number we have available and, if necessary, leaving a voicemail message or a message on your answering machine, or a message with a person, other than you, who answers your telephone unless you tell us not to, or (4) other means of communication (e.g., patient portal, text messaging, etc.).

*__Treatment Alternatives.__ We may use or disclose your health information to let you know about treatments that may be offered to you so you can make good choices about your health care.

*__Health-Related Benefits and Services.__ We may use and disclose health information to tell you about health benefits or services that may be of interest to you.

YOUR CHOICES. For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

(1) In these cases, you have both the right and choice to tell us to:

*__Share Information with Your Family, Close Friends, or Others Involved in Your Care; Disaster Relief.__ We may disclose your location or general condition to family members, your personal representative, or another person identified by you. If any of these individuals are involved in your care or payment for your care, we may also disclose information as is directly relevant to their involvement. If you are not able to tell us a preference, for example, if you are unconscious, incapacitated, in an emergency situation, or unavailable, we may go ahead and share your information if we believe it is in your best interests. Also, we may disclose your health information as part of a disaster relief effort so your family knows about your condition, status, and location.

*__Facility Directory.__ We may disclose limited information about you which will be available to the public via the Facility's directory. While you are here at the Facility as a patient, the information we disclose may be your name, room number in the Facility, and your general condition (for example, "Fair," "Stable," etc.) and your religion. All the above information (except your religion) may be released to anyone who asks for you by name. Your religion may be given to a minister, priest, or rabbi even if they do not ask for you by name. The Facility maintains a facility directory so your relatives, friends, and religious persons can visit you in the Facility. If you do not want this information shared, you must write the Facility or note your preference on the admission/consent form. If you are not able to tell us a preference, for example, if you are unconscious, incapacitated, in an emergency situation, or unavailable, we may go ahead and share your information if we believe it is in your best interests.

*__Contact You for Fund-raising Activities__. We may use and disclose your health information, including your name, address or other contact information: age, insurance status, gender, date of birth, department of service, treating physician, and outcome information for Fund-raising purposes. We may contact you to help our

Facility raise money. We may also disclose your health information to a foundation, so it can help the Facility raise money. In the case of Fund-raising, if you do not want the Facility to contact you for Fund-raising efforts, you must notify the Contact Person using the contact information on Page 1.

(2) In these cases, we never share your information unless you give us written authorization:

*__Marketing, Sale, and Psychotherapy Notes__**.** Most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes, and uses and disclosures that constitute a sale of your health information require your authorization.

> *__Psychotherapy Notes.__ Psychotherapy notes are a particular type of health information. Mental Health records generally are not considered psychotherapy notes. Your authorization is necessary for us to disclose psychotherapy notes.
>
> *__Marketing and Sale of Health Information__**.** There are some circumstances when we may directly or indirectly receive a financial (e.g., monetary payment) or non-financial (e.g., in-kind item or service) benefit from a use or disclosure of your health information. Your authorization is necessary for us to sell your health information. Your authorization is also necessary for some marketing uses of your health information.

ADDITIONAL WAYS WE USE OR SHARE YOUR HEALTH INFORMATION. We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet certain conditions in the law before we can share your information for these purposes.

*__Research__**.** Under certain circumstances, we may use and disclose your health information for medical research. All research projects, however, are subject to a special approval process. Before we use or disclose your health information for research, the project will have been approved.

*__As Required by Law__**.** We will share health information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. Things like wounds from weapons, abuse, communicable diseases, and neglect are examples of such information and we do not need your permission to disclose this information.

*__To Avoid a Serious Threat to Health or Safety__. We may use or disclose your health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

*__Organ and Tissue Donation__**.** If you are an organ donor, we may disclose your health information to people who deal with organ collection, eye or tissue transplants, or to a donation bank. We give your information to these people to make sure organ or tissue donation or transplants can be made.

*__Military and Veterans__**.** If you are a member of the armed forces, we may disclose your health information as required by those military authorities in command. If you are a member of the military of another country, we may release your health information to the authority in command in your country.

*__Worker's Compensation__**.** If you are involved in an injury that happens while you are at work, we may have to disclose your health information so your medical bills can be paid by your employer. The Facility may disclose your health information for worker's compensation and similar programs to the extent necessary to comply with the law.

*__Public Health Risks.__ We may disclose your health information without your permission if there is a danger to the public's health. Some general examples of these dangers include: to avoid disease, injury or disability; to report births and deaths; to report child abuse and neglect; to report reactions to drugs and other health products; to report a recall of health products or medications; to tell a person he/she has been exposed to a disease or may get a disease or spread the disease; to tell a government authority if we believe an adult patient has been abused, neglected, or the victim of violence, however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information; to let employers know about a workplace illness or workplace safety; and/or to report trauma injury to the state. We may also, with consent, give immunization information to a school.

*__Health Oversight Activities.__ We may disclose your health information without your permission to a special group who checks up on hospitals to make sure they are following the rules. These special groups investigate, inspect, and license hospitals. This is necessary for our government to know about our hospitals and that they are following the rules and the laws.

*__Lawsuits and Disputes.__ We may disclose your health information if you are involved in a lawsuit or dispute. If a court orders that we disclose your health information, even if you are not involved in a lawsuit or dispute, we may also disclose your health information. Other reasons that may cause us to release your health information would be if there is an order to appear in court, a discovery request, or other legal reason by someone else involved in a dispute. There must be an effort made to tell you about this request or an order to make sure that the information they want is protected.

*__Law Enforcement.__ We may disclose your health information if asked for by a police official for the following reasons: a court order, subpoena, warrant, or summons; to find a suspect, fugitive, witness, or missing person; regarding a crime victim, if we obtain the person's agreement, or, under certain circumstances, if we are unable to obtain the person's agreement; about a death we believe may be the result of a crime; about some crime that happens at the Facility; or in emergencies, to report a crime, the place where the crime happened, the victim of the crime, or the identity, description or whereabouts of the person who committed the crime.

*__Coroners, Medical Examiners and Funeral Directors.__ We may disclose health information to a coroner or medical examiner to identify a person who has died or to determine the cause of death. We may also disclose health information to funeral directors so they can carry out their duties. We are required to protect your health information for fifty (50) years following your death.

*__National Security and Intelligence Activities.__ We may disclose your health information to federal authorities for intelligence, counter-intelligence, and other situations involving our national safety.

*__Protective Services for the President and Others.__ We may disclose health information about you to federal officials so they can protect the President or other officials or foreign heads of state or so they may conduct special investigations.

*__Inmates.__ If you are an inmate of a prison or placed under the charge of a law enforcement official, we may disclose your health information (1) to the prison to provide you with health care; (2) to protect the health and safety of you and others; or (3) for the safety of the prison.

Your Rights Regarding Electronic Health Information Exchange.

Cheyenne County Hospital participates in electronic health information technology or HIT. This technology allows a provider or a health plan to make a single request through a health information organization or HIO to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or health care operations. HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures. You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything. Second, you may restrict access to __all__ of your information through an HIO (except as required by law). If you

wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. This form is available at http://www.KanHIT.org. You cannot restrict access to certain information only; your choice is to permit or restrict access to all of your information. If you have questions regarding HIT or HIOs, please visit http://www.KanHIT.org for additional information. If you receive health care services in a state other than Kansas, different rules may apply regarding restrictions on access to your electronic health information. Please communicate directly with your out-of-state health care provider regarding those rules.

OUR RESPONSIBILITIES.

* We are required by law to maintain the privacy and security of your health information.

* We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

* We must follow the duties and privacy practices described in this Notice and give you a copy of it.

* We will not use or disclose your health information other than as described herein without your authorization. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. If you revoke your authorization, it will not be effective for any uses and disclosures we have already made in reliance on your prior authorization.

CHANGES TO THE TERMS OF THIS NOTICE. We may change the terms of this Notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in the Facility, and on the Facility's website. You will find the date the Notice takes effect at the top of the first page below the title. You can get a copy of this Notice at any time by contacting the Contact Person listed above.

DISCRIMINATION IS AGAINST THE LAW

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

Cheyenne County Hospital:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages.

If you need these services, contact **Shawna Blanka**

If you believe that Cheyenne County Hospital has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **Shawna Blanka**, PO Box 547 St. Francis, KS 67756, phone: 785-332-9088 or 785-332-2104, fax: 785-576-1065, email: sblanka@cheyennecountyhospital.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, **Shawna Blanka** 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/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

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-xxx-xxx-xxxx（TTY：1-xxx-xxx-xxxx）。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx)번으로 전화해 주십시오.

ŇĆπΔİi : ĂğİĔğİ ĀğİĄŃğİĊİĞİ ĒİĘ, ʃİĄį ĒʃİĄĞĘΩŃĞĢπğİĄĊİĞİ, ŃπΩÛŃĕīŢğİ, ŇĔğĄďĠĢĔŅĝĀğİĄ. ŇĀĖ 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-xxx-xxx-xxxx (رقم هاتف الصم والبكم: 1-xxx-xxx-xxxx).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-xxx-xxx-xxxx (ATS : 1-xxx-xxx-xxxx).

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-xxx-xxx-xxxx（TTY:1-xxx-xxx-xxxx）まで、お電話にてご連絡ください。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-xxx-xxx-xxxx (телетайп: 1-xxx-xxx-xxxx).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx) تماس بگیرید.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဥ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx) သို့ ခေါ်ဆိုပါ။

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

[Taglines specific to Nebraska]

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-xxx-xxx-xxxx (टिटिवाइ: 1-xxx-xxx-xxxx)

ئاگاداری: ئەگەر بە زمانی کوردی قەسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆرایی، بۆ تۆ بەردەستە. پەیوەندی بە 1- xxx-xxx-xxxx) TTY (1- xxx-xxx-xxxx.بکە

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).