



## **PUBLIC BENEFITS IN MISSISSIPPI FOR 2009**

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### **Health Care -Sources of Assistance**

#### **Mississippi Medicaid:**

Medicaid is a national medical assistance program established by Title XIX of the Social Security Act and is funded by the federal government and the states. It helps pay for medical services for low-income people who fall into specific categories or groups, which generally include the elderly, blind, disabled, pregnant women and children.

#### **State Agency:**

In Mississippi, the Medicaid program is administered under the Office of the Governor by the Division of Medicaid (DOM). The DOM determines the eligibility of applicants and administers payment for medical services directly to health care providers.

#### **Benefits:**

Medicaid does not directly provide health care services and does not provide beneficiaries with money to purchase health care services. Instead, Medicaid reimburses participating providers - including hospitals, nursing homes, pharmacies, doctors and dentists - for health care services rendered by them to Medicaid recipients.

#### **Eligibility - Citizenship:**

The applicant must be a United States citizen or an alien lawfully admitted for permanent residence. Applicants must also be residents of Mississippi.

#### **Coverage groups for the aged and disabled:**

##### **1. Supplemental Security Income (SSI) Category:**

Full Medicaid coverage is generally available in this category.

Individuals who are aged 65 or over, or who are blind or disabled according to the Social Security Administration standards will qualify for SSI by meeting income and resource guidelines.

**SSI Standards:**

**Income limits:**

Individual      \$674 (2009)  
Couple            \$1,011 (2009)

**Resource limits:**

Individual      \$2000 (for SSI) \$4000 (for Medicaid)  
Couple            \$3000 (for SSI) 6000 (for Medicaid)

**See list of exempt resources below.**

**2. Medicaid Long Term Care** (nursing home level of care in the institution or home and community based waiver care)

Nursing home charges are outside the reach of most families. More than half of all nursing home care is paid for by **Medicaid**. Medicaid coverage is available for **custodial care** that consists of observation and helping the patient with activities of daily living in the nursing home setting, as well as for the higher level of care, called skilled care. Medicaid coverage currently is unlimited in terms of the number of days of coverage.

**Requirements for Medicaid coverage for Long Term Care**

Age 65 or older, blind or disabled under SSA rules

A physician must certify that the nursing facility level of care is needed.  
The nursing facility or home health agency must be a qualified Medicaid provider.

**Income limits:**

Up to \$2,022/month (2009).

If an individual's income exceeds \$2,022/ month (2009) a trust may be established to qualify the individual for Medicaid long term care coverage. The amount placed in trust will be paid to the state for reimbursement of Medicaid payments for nursing home care made on behalf of the individual. The income up to \$2,022 (2009) is paid to the nursing home, after certain allowed deductions. This is called patient pay amount or share of cost. Medicaid pays the difference between the patient's share and the Medicaid rate.

**Resource limits:**

Up to \$4000 (non-exempt resources)

**Exempt Resources:**

**Exempt resources are not counted in determining eligibility for Medicaid.** They are called exempt resources. These include, among other things:

- A home with equity of up to \$500,000 in value (may be increased to \$750,000)
- Household goods
- Up to 2 vehicles
- Family burial plots
- A fund for funeral expenses up to \$6000
- Life insurance of \$10,000 or less face value on each person
- Term life insurance regardless of value
- Income producing property/ net annual return of 6% produced
- Personal property with equity value of \$5,000.00 or less.

Required deductions from income from patient share of cost include:

1. Personal needs allowance (\$44/mo.)
2. Allowance for spouse and dependent children
3. Medical expenses incurred: i.e., health insurance premiums, deductibles and coinsurance, other necessary medical and remedial care.

**Financial Protections for Spouses receiving Medicaid Long Term Care benefits**

In 1989 Congress amended the Medicaid laws to address the financial problems of the spouses of individuals in nursing homes (community spouses). These laws provide protections to prevent spousal impoverishment when an individual qualifies for nursing home care.

**Income:** The community spouse is entitled to a monthly maintenance needs allowance of up to \$2739/month (effective 1-1-2009). This means that, with some exceptions, the income of the spouse in the nursing home goes to the community spouse to make up the difference between the community spouse's income and the monthly allowance amount, before payment is made to the nursing home.

**Resources:** The community spouse is entitled to a resource allowance of up to \$109,560 (effective 1-1-2009). This is in addition to exempt resources.

Once an individual enters a nursing home, his spouse's **income** is no longer considered available to him, and will not disqualify him for Medicaid. Once an institutional spouse is determined to be eligible for Medicaid, no **resources** of the community spouse can be deemed to be available to the institutionalized spouse and will not disqualify him for Medicaid.

**Transfer of Assets -Disqualification from Medicaid Long Term Care Benefits**

**Transfers of assets for less than fair market value** by an individual or spouse **within 60 months** of application for Medicaid for **nursing home** or waived home care services result in denial of Medicaid coverage during a penalty period. The **penalty** period for nursing home coverage is calculated by dividing uncompensated value of the assets transferred by a statewide average monthly cost of nursing home care (\$4600 per month plus a formula for the number of days for a partial month).

The period of ineligibility for home and community based waiver care for a transfer of assets within the previous 60 months is 60 months, unless the asset is returned. This is a change that was put in place by the Mississippi Division of Medicaid as of January 1, 2006, pursuant to the Deficit Reduction Act of 2005. *Prior to 2006, the penalty period assessed for transfers of assets in the home and community based waiver program were the same as the formula for transfer penalties for nursing home care.* **Transfer of assets penalties apply only to Medicaid coverage for nursing facility care or care under the home and community based waiver programs.**

**Assets** affected include all income and resources of the individual and spouse. Assets include those to which the individual or spouse was entitled but did not receive due to action on their part. Examples of such action are waiving pension income or right to receive an inheritance, not "accepting or accessing" a personal injury settlement, have a tort settlement diverted into a trust, or refusing to take legal action to obtain court-ordered support.

**Fair Market Value.** The care provided by family members is presumed to be free, unless a written agreement was made at the time the care was given that compensation is intended.

A transfer of the remainder interest in real property whereby a life estate interest is retained is a transfer of assets that is subject to the Medicaid rules. The value of the remainder interest is computed using the "Life Estate and Remainder Interest Table" which is in the Appendix of the Medicaid Eligibility Manual, Volume III, which can be accessed from the column on the left hand side of the Medicaid website home page, located at [www.dom.ms.gov](http://www.dom.ms.gov).

Medicaid will use the tax assessor's value for real property. This amount can be rebutted with other evidence.

**Exceptions to Transfer Penalties are as follows:**

**Transfer of the home to:** spouse, dependent or disabled child; a brother or sister who has equity interest in the home and was residing in the home for at least a year before the individual's admission to the nursing home; child of the individual who was residing in the home for at least two years prior to the individual's admission and who provided care which allowed the person to live at home rather than an institution.

**Transfers to a spouse or to another for the sole benefit of the spouse;** transfers from the spouse for the sole benefit of the spouse; transfer to a trust solely for the benefit of the individual's blind or disabled child, and transfers to a trust solely for the benefit of a disabled individual under age 65.

**Transfers** where a satisfactory showing is made to the state that (a) the individual intended to dispose of the assets **for fair market value**, (b) the assets were transferred exclusively **for a purpose other than to qualify for Medicaid**, or the **transferred assets were returned to the individual**.

**Transfers where applying the penalty would work undo hardship.** Hardship criteria include cases where (1) the applicant has no way to pay, (2) the transfer was not knowingly authorized, or (3) the individual assigns rights to recover the transferred asset to the State. At minimum, states must allow hardship waiver if the absence of Medicaid would deprive the individual of medical care so that his life would be endangered, or if necessities of life would be denied. The state must provide notice, a hearing process and a separate process for appealing an adverse decision.

**Jointly-held assets:** An asset held with another person is considered to be transferred when any action is taken that reduces the individual's ownership or control of it. The addition of another name to an account may not necessarily constitute an impermissible transfer, unless that action actually restricts the applicant's rights concerning the property. Withdrawal of funds by another joint tenant is viewed as a transfer. Regulations concerning joint ownership of **bank accounts** (but not other jointly held property) establish a rebuttable presumption of complete ownership of the joint account by the Medicaid recipient.

**Nursing Home care under Medicare - Medicare** coverage for nursing home charges is limited to 100 days of **skilled** care per spell of illness. Medicare pays 100% of approved charges for days 1-20 in the nursing home. Medicare covers approved charges in excess of the \$133.50 co-insurance amount (2009) for days 21-100. After day 100, **Medicare** pays nothing for nursing home care per spell of illness. A spell of illness begins when an individual checks into a hospital or nursing home and continues for sixty days after the individual has been discharged from the institution. If an individual enters a hospital or nursing home after the end of a spell of illness, the benefits, deductibles and co-payments again apply. Medicare does not cover custodial care in the nursing home.

### 3. **Disabled Children Living at Home (DCLAH)**

The doctor certified the need for long term care or acute care (nursing home or hospital care).

The child can receive the same level of care at home.

The cost of the care at home is no more than that of nursing home or hospital care.

The income limit for the child's own income is no more than \$2,022/month

#### 4. **Qualified Medicare Beneficiaries (QMB)**

Pays Medicare premiums, deductibles and coinsurance.

Applicants must be eligible for Medicare, Part A (Hospital Insurance)

##### **Income limits:**

Individual	\$953
Couple	\$1,265

##### **Resource limits:**

There is no resource test for this category.

#### 5. **SLMB and QI-1**

This category pays only the Medicare Part B premium (\$96.40/month - remains unchanged for 2009).

Applicants must have Medicare Part A (Hospital Insurance)

##### **Income limits:**

Individual	\$1269
Couple:	\$1690

##### **Resource limits:**

There is no resource test for this category.

#### 6. **Working and Disabled**

To qualify for this group, the applicant must

Be working at least 40 hours per month

Be determined disabled

Have gross monthly **earned income** less than:

Individual	\$4,579
Couple	\$6,137

Have total monthly **unearned income** up to:

Individual	\$1269
Couple	\$1690

Have total **resources** up to:

Individual	\$24,000
Couple	\$26,000

## 7. The Healthier MS Waiver

Applicant must:

Not be entitled to Medicare

Be determined to be disabled under SSA rules of be age 65 or over

Have gross monthly income less than

Individual \$1269

Couple \$1690

Have total countable resources less than:

Individual \$4000

Couple \$6000

This waiver has a \$5,000 beneficiary enrollment cap at all times.

## 8. The MississippiCAN Coordinated Care Program (1915(b) Federal Waiver

The Mississippi Medicaid website at [www.medicaid.ms.gov](http://www.medicaid.ms.gov) home page has a link to information about a new program that Mississippi is seeking to establish under a Federal Medicaid 1915(b) waiver. The program would be statewide and would be mandatory for certain people who are eligible for Medicaid. The information states that the program is scheduled to begin on October 1, 2009. Enrollment in the program will be mandatory for targeted populations. There will be no ability to opt out of the program. The targeted populations are four groups:

- Pregnant women
- Children under the age of one year
- Targeted, high cost Medicaid beneficiaries in the following categories:
  - SSI
  - Disabled Child at Home
  - Working Disabled
  - Department of Human Services Foster Care
  - Breast/Cervical Group

Persons in an institution such as a nursing home, ICF/MR or PRTEF; dual eligibles (Medicare and Medicaid); and waiver members are excluded from the program regardless of the category of eligibility. The goals of the program are to improve access to needed services, improve quality of care and improve efficiencies and cost effectiveness through the State contracting with Coordinated care Organizations (CCOs) on a full risk capitated care basis. Beneficiaries in the targeted groups will be required to choose the CCO of their choice to receive their benefits. See the Mississippi Medicaid website for more information.

## Medicare

### Medicare Insurance Basics:

Established by Congress in 1965

## **Unlike Medicaid, Medicare is not a “need-based” program**

### **Traditional Medicare is a success story**

Before Medicare only about 50% of people age 65 or older had health insurance  
By 1970 (4 years after Medicare) 97% had health insurance  
Life expectancy of older people increased  
Poverty level among older people and their families decreased  
Beneficiaries felt more secure

### **Trend toward privatization of Medicare**

For 10 years Congressional and Executive policy has shifted away from traditional Medicare  
Part C (now called Medicare Advantage) has been expanded.  
Part D drug coverage is only offered through private plans  
CMS promotes managed care plans

### **Eligibility**

Medicare is a health insurance program for:  
People age 65 or older  
People under age 65 with certain disabilities  
People of all ages with end-stage renal disease

## **Medicare Parts**

### **Part A**

Part A provides coverage for the following care:

Hospital (acute care)  
Skilled nursing facilities (Nursing Home Care)  
Hospice care  
Home health care

Part A - 2009 premiums and co-payments:

Monthly Premiums

\$0 with 40 covered quarters  
\$244 with 30 -39 covered quarters and certain others  
\$443 with less than 30 covered quarters

Hospital Deductible per benefit period

\$1068

Hospital Co-Pay

\$0 Days 0 to 60 per benefit period  
\$267 Days 61 - 90 per benefit period  
\$534 Days 91 - 150 per benefit period

Skilled Nursing Facility Co-Insurance

\$0	Days 0 - 20 per benefit period
\$133.50	Days 21 to 100 per benefit period

## Part B

Part B provides coverage for the following care:

- Physician's services
- Outpatient care
- Durable medical equipment and supplies
- Physical and occupational therapy
- Home health care

Part B 2009 Premiums and Co-payments

Part B Monthly Premiums

- \$96.40 (income up to \$85,000)
- \$134.90 (income from \$85,001 - \$107,000)
- \$192.70 (income from \$107,001 - \$160,000)
- \$250.50 (income from \$160,001 - 213,000)

Part B deductible

\$135 per year

Part B Co-payments

20% of Medicare approved amount for services after the \$135 deductible is met. \*(Note, physicians who accept Medicare may charge up to 15% more than the Medicare approved amount.)

## Part C

Medicare Advantage Plans (Privatization of Medicare)

- **Enrollment if voluntary.**
- These plans are offered by private insurance companies to those who are enrolled in Medicare Parts A and B. Medicare Advantage Plans provide all of your Part A and Part B coverage. This means that Part C must cover at least all of the services that Original Medicare covers.
- However, each Medicare Advantage Plan may charge different out-of-pocket costs. It is important to call any plan prior to joining to find out the plan's rules and to make sure it fits your needs.

Pros and Cons

- Pros
  - Medicare Advantage Plans may offer extra coverage such as vision, hearing, dental, or health wellness programs
  - Most include prescription drug coverage (at extra cost)
  - You still have all the rights that you would have under Original Medicare, including the right to appeal.

- You can join even with a pre-existing condition. (Except End-Stage Renal Disease)
- You don't need to buy (and can't be sold) a Medigap (Medicare Supplement Insurance Policy).

-Cons

- In some plans, if you see a doctor or service provider who doesn't participate in the plan your services may not be covered at all, or your costs will be higher.
- In rural areas of the county, it is usually advisable not to enroll in one of these Part C plans. Instead, it usually will be best to remain in traditional Medicare Parts A and B and purchase a stand alone Part D prescription plan.

#### Things to Consider Before Enrolling

- Does the plan include Part D prescription coverage?
- Review the coverage provided by the original Medicare program by Medigap insurance policies and by Medicare Advantage Plans
- Determine what plan services are provided at additional cost and how much
- Ask about plan physicians and determine if their physicians are in the plan

#### More Information

- Visit [www.medicare.gov](http://www.medicare.gov), or call 1-800-MEDICARE (1-800-633-4227) to find plans in your area. TTY users should call 1-877-486-2048
- Source: <http://www.medicare.gov>, <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>

## Part D

### Medicare Prescription Drug Plans

#### Introduction

If you have Medicare and you want prescription drug coverage, then you must enroll in a Medicare Prescription Drug Plan. These plans are available through private companies that work with Medicare to provide prescription drug coverage.

Anyone who has Medicare Part A and/or B may enroll during the enrollment periods. Even if you do not take many prescription drugs, you should still consider enrolling in Part D. If you decide not to join a Medicare drug plan when you are first eligible, and you don't have other creditable prescription drug coverage (such as coverage through a union or employer) you will likely pay a late-enrollment penalty through higher premiums if you choose to join later on.

#### Joining

Once you choose a Medicare drug plan, you may be able to join by completing a paper application, enrolling online, or by calling the plan. **Note that Medicare drug plans aren't allowed to call you to enroll in the plan.** Visit [www.medicare.gov](http://www.medicare.gov) or call 1-800-MEDICARE for a list of Medicare plans in your area.

Once you join, you must stay enrolled for that calendar year. However, under certain circumstances, you may be able to join, drop, or switch a Medicare drug plan during a special enrollment period. These circumstances include moving out of the service area, lose other creditable prescription drug coverage, live in an institution, or qualify for "extra-help."

Source: <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>

### **"Extra-Help"**

"Extra-Help" is a Medicare program that aids people with limited income and resources in paying Medicare prescription drug costs.

You may qualify for "Extra-Help" if your yearly income and resources are below the following:

	Income Limit	Resource Limit
Single	\$16,245	\$12,510
Married (living w/ spouse & no other dependants)	\$21,855	\$25,010

**Beginning January 1, 2010, the following changes make it easier to qualify for Extra Help:**

- 1. Life insurance is no longer counted as a resource**
- 2. Help received on a regular basis from another person to pay for household expenses – food, mortgage, rent, heating fuel, or gas, electricity, water, and property taxes will no longer count as income.**

For more information of what counts as income and resources, visit the Social Security Website at <http://www.ssa.gov/pubs/10508.pdf>

You may also automatically qualify for "Extra-Help" if you have Medicare and one of the following:

- Full Medicaid Coverage
- You belong to a Medicare Savings Program
- You get Supplemental Security Income (SSI) benefits

If you automatically qualify, then Medicare will send you a letter. You don't need to apply if you receive this letter. If you don't automatically qualify, you may apply for

“Extra-Help” by contacting Social Security at 1-800-772-1213 or by visiting Social Security’s website at [www.socialsecurity.gov](http://www.socialsecurity.gov) to apply online.

If you qualify for “Extra-Help” you will get help paying your Medicare drug plan’s monthly premium, yearly deductible, coinsurance and co-payments, and you will have no coverage gap. Note that the exact amount you pay under the “Extra-Help” program depends on the level of “Extra-Help” you receive. Contact your plan to find the exact amount.

Source: <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>

## Food Stamps (SNAP)

Generally

As of October 1, 2008 the food stamp program changed its name to the Supplemental Nutrition Assistance Program (SNAP). The SNAP program provides monthly benefits that help low income households buy the food they need.

### Eligibility Requirements

Households have to meet income tests unless *all* household members are receiving TANF, SSI, or other assistance programs. Most households must meet both a gross and net income test. However, a household with an elderly person or a person receiving certain types of disability payments only needs to meet the net income test. Households, except those mentioned above, must have income under the amounts listed below:

Household Size	Gross Monthly Income	Net Monthly Income
1	\$1174	\$903
2	\$1579	\$1215
3	\$1984	\$1526
4	\$2389	\$1838
5	\$2794	\$2150
6	\$3200	\$2461
7	\$3605	\$2773
8	\$4010	\$3085
Each Add. Member	+\$406	+\$312

Note that “gross monthly income” means a household’s total, non-excludable income before any deductions have been made. Net income means gross income minus allowable deductions. If you determine that your gross monthly income is less than the maximum amount, this does not necessarily mean that you qualify for SNAP. You must then determine your net monthly income. The calculation of net monthly income depends on a number of factors including whether or not you are eligible for a variety of deductions

including those for dependant care, child support, medical expenses for elderly, and shelter. To determine your net monthly income call the Mississippi Department of Health Services at 1-800-948-3050, or visit the USDA's Food and Nutrition Service website at [http://www.fns.usda.gov/fsp/applicant\\_recipients/eligibility.htm#deductions](http://www.fns.usda.gov/fsp/applicant_recipients/eligibility.htm#deductions).

### Benefits

If you qualify for SNAP assistance, the following chart is a guide to the *maximum* benefit you may receive:

People In Household	Maximum Monthly Allotment
1	\$200
2	\$367
3	\$526
4	\$668
5	\$793
6	\$952
7	\$1052
8	\$1202
Each Add. Person	+\$150

To determine the *actual* amount you will receive multiply your net income by 30%, round up to the nearest dollar, and then subtract this number from the maximum monthly allotment to determine what you will receive.

Example: Household of 4 with a net monthly income of \$1,089.  $(\$1,089 * .30) = \$326.70$  (round up to \$327.00).  $\$668.00 - \$327.00 = \$341.00$

### **Public Benefits Available to Grandparents Caring for Grandchildren**

#### 1. Medicaid

- a. Medicaid may be available to provide health insurance for children being cared for by their grandparents. Medicaid may also be available to the grandparent, if they qualify.
- b. The income of the grandparent will not be deemed to the grandchild unless the grandparent has legally adopted the grandchild.
- c. A minor child may apply for Medicaid themselves if the minor is pregnant, is over the age of 17, is married and living with a spouse, is living independently, or is living with his/her parents and is applying for his/her own children.

- d. If the grandchild may not apply for Medicaid themselves, then an authorized or designated representative may apply on their behalf. A grandparent may fill this role. No formal, legal relationship such as guardianship or adoption is required.
- e. The grandparent **MUST** assist in any collection of child support to be eligible for Medicaid.

2. Children's Health Insurance Program (CHIP)

- a. CHIP provides insurance coverage for uninsured children up to age 19 whose family income does not exceed 200% of the federal poverty level.
- b. For a child to be eligible for CHIP, he/she must be uninsured and not eligible for coverage under Medicaid.
- c. Unless the grandparent has legally adopted the grandchild, the grandparent's income will not be deemed to the grandchild.
- d. There is no formal relationship requirement.
- e. There is no requirement for assisting in the collection of child support for CHIP.

3. Temporary Assistance to Needy Families (TANF)

- a. TANF is a program that provides money payments for children and their needy caretaker relatives who do not have enough income or resources to meet everyday needs. A grandparent head of householder who is caring for their minor grandchild qualifies as a caretaker relative, regardless of whether or not they have legally adopted the child.
- b. There is no formal relationship requirement.
- c. Assisting in the collection of child support payments is a requirement for receipt of TANF benefits.

4. Supplemental Nutrition Assistance Program (Food Stamps)

- a. Grandparents caring for their grandchildren may be eligible for food stamps if they qualify. Eligibility for food stamps is determined by household income, so income earned by a grandparent will qualify as household income. However, income earned by a household member who is 17 years or younger will not be included in household income if he/she is attending elementary or secondary school.
- b. There is no formal relationship requirement for receipt of food stamp benefits. Low-income households may qualify for food stamps. A "household" is defined as "an individual who lives alone or who, while living with others, customarily purchases food and prepares meals for home consumption separate and apart from

the others; or a group of individuals who live together and customarily purchase food and prepare meals together for home consumption.” So, a grandparent who lives with his/her grandchild and purchases food for home consumption qualifies as a household.

- c. Grandparents must assist in the collection of child support as a condition for eligibility for food stamps
5. Social Security Dependant Benefits
- a. Social security payments may also be made to spouses and children of retired workers. These are called SSA Dependant Benefits. Survivor’s benefits may also be paid to surviving widow(er)s and children of insured individuals.
  - b. For a grandchild to be eligible for SSA dependant benefits from the grandparent, the grandchild must have been legally been adopted by the grandparent.
6. Supplemental Security Income (SSI)
- a. Supplemental Security Income is available to those who are aged, blind, or disabled (including children under the age of 18)
  - b. A disabled child living being cared for by his/her grandparents will most likely not have their grandparent’s income deemed to them since the relevant statute provides that only income of parents or step-parents will be deemed to the child. The statute further defines “parent” as a natural or adoptive parent, and makes no mention of third-party caretakers. However, if a grandparent legally adopts his or her grandchild, then the grandparent’s income will be deemed to the grandchild.
  - c. There is no requirement that a grandparent assist in the pursuit of child support for their grandchild to be eligible for SSI.

### **CONSUMER INFORMATION**

Block Credit Card Offers:

Call the toll-free number 1-888-567-8688 or visit [www.optoutprescreen.com](http://www.optoutprescreen.com). Both are operated by the three major credit bureaus and are free of charge. You’ll have to provide your name, address and Social Security number, information that will be “used only to process your request to opt out”, according to the FTC website. You can opt out for family members as well, if you are their legal guardian - i.e. children. Opting out lasts for five years unless you follow up with a written request to make it permanent. If you have joint credit with a spouse or partner, you both have to opt out. If you change your mind and want a new credit card you can always reverse the procedure and “opt in.”

Block Telemarketers:

Register your telephone number by calling the toll-free number at 1-888-382-1222 or registering on-line at [www.donotcall.gov](http://www.donotcall.gov).

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