



Appointment Date: _____ Time: _____

ELKO COUNTY HUMAN SERVICES

571 Idaho Street (Mailing)

540 Court Street (Physical)

Elko, NV 89801

(775) 738-4375 Phone • (775) 738-5984 Fax

IMPORTANT

- Please provide the office with **all required documentation** on or before your appointment date.
- Please arrive to your appointment on time, as scheduled; otherwise, you may be rescheduled for a later date.
- If you are not able to attend your appointment, please call at least 30 minutes in advance to reschedule or cancel.
- If you have any questions or concerns, please call the office at (775) 738-4375.

In order to evaluate your application for assistance, Elko County requires applicants provide the following documentation accompanied by a completed application. Without the required information, your request will not be processed and may result in denial and/or termination of benefits or services.

REQUIRED DOCUMENTATION

- ☐ Identification for all members of the household.
 - Adults – Photo ID and social security card.
 - Children under age 16 – Birth certificate or social security card.
- ☐ Verification of all income in the last 60 days for all members of the household.
 - Pay stubs
 - Social Security Income (SSI, SDI, etc.)
 - Child support/alimony
 - Retirement/Pension
 - Unemployment
 - Income Tax Return
 - Any other source of income in the last 60 days.
- ☐ Bank Statements for all accounts within last 30 days.
- ☐ Proof of all assets.
 - Vehicle registration or title.
 - Rental property, etc.
 - Stocks, bonds, annuities, etc.
- ☐ Proof of other assistance.
 - SNAP, Medicaid, etc.
 - Section 8 Housing
 - Energy Assistance Program
- ☐ Lease/rental agreement* or mortgage statement.
*(must be notarized if effective after July 1, 2017 unless rental is managed by a Property Management Company)
- ☐ Copies of most recent utility bills including electric, gas, water, sewer, and trash.
- ☐ Other documents requested by Human Services staff.

ADDITIONAL DOCUMENTATION REQUIRED FOR ASSISTED LIVING APPLICANTS

- ☐ Admission Form – completed by facility
- ☐ Physician's Report of Examination – completed by physician.
- ☐ Proof of Health, Life, and Burial policies



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APPLICATION FOR ASSISTANCE

APPLICANT INFORMATION

Name: _____ Other Names Used: _____

Phone Number: _____ E-mail: _____

Address: _____

Mailing Address (if different): _____

City: _____ State: _____ Postal Code: _____

Have you lived in Nevada for at least 2 (two) years? _____

TYPE OF ASSISTANCE REQUESTED

☐ RENT ☐ UTILITIES ☐ ASSISTED LIVING

If requesting rental assistance, name of landlord: _____

HOUSEHOLD MEMBER INFORMATION

Household Member Name Last, First, Middle Initial	Social Security #	Gender		Birth Date	Age	Relation to Head of Household	YES OR NO		Race* use code below
		Female	Male				Disabled	Veteran	
		☐	☐			SELF			
		☐	☐						
		☐	☐						
		☐	☐						
		☐	☐						
		☐	☐						

*Race – A – Asian; B – Black or African American; N – Native American; P – Pacific Islander/Hawaiian; W – White; M – Multi-race

Are any of the individuals listed above pregnant? ☐ YES ☐ NO If yes, due date: _____

CURRENT ASSISTANCE

Is any member of the household currently receiving or has applied for the following assistance?

TYPE OF ASSISTANCE	AMOUNT RECEIVED	DATE BEGAN	DATE ENDED	PERSON WHO RECEIVES ASSISTANCE
SNAP (FOOD STAMPS)				
INDIAN COMMODITIES				
WIC				
MEDICAID				
MEDICARE				
NEVADA CHECK-UP				

Have you ever received assistance from Elko County Human Services? ☐ YES ☐ NO ☐ UNSURE

If yes, type of assistance: _____ Date of Service: _____

OTHER HOUSEHOLD INFORMATION

Family Type

- ☐ Single Person
- ☐ Two parent family
- ☐ Single parent family (father only)
- ☐ Single parent family (mother only)
- ☐ Two adults/no children
- ☐ Foster family
- ☐ Other _____

Marital Status

- ☐ Never Married
- ☐ Married, living with spouse
- ☐ Married, not living with spouse
- ☐ Living together
- ☐ Divorced
- ☐ Widowed
- ☐ Other _____

Housing Status

- ☐ Own
- ☐ Rent
- ☐ Homeless
- ☐ Other _____

Transportation

- ☐ Private Vehicle
- ☐ Relatives/Friends/Neighbors
- ☐ Public Transportation
- ☐ Other _____

How long at current residence? _____

Emergency Contact – Not in household

Name: _____ Phone Number: _____

EARNED INCOME

HOUSEHOLD INCOME FOR ALL HOUSEHOLD MEMBERS FOR PAST 60 DAYS.		
HOUSEHOLD MEMBER NAME	SOURCE	AMOUNT
Total monthly income for household		

CURRENT EMPLOYMENT

HOUSEHOLD MEMBER NAME	EMPLOYER	BEGIN DATE	FULL-TIME/ PART-TIME	PERMANENT/ TEMPORARY	RATE OF PAY	JOB TITLE

How many hours have you worked in the last 30 days? _____

How often are/were you paid? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other _____

WORK HISTORY – PREVIOUS 12 MONTHS

HOUSEHOLD MEMBER NAME	EMPLOYER	BEGIN DATE	END DATE	JOB TITLE	AVG WEEKLY HOURS	REASON LEFT (LAID OFF, QUIT, FIRED)

Is any adult currently enrolled in college? ☐ YES ☐ NO

If yes, who? _____ Name of College: _____

UNEARNED INCOME

TYPE OF INCOME	AMOUNT RECEIVED	DATE BEGAN	DATE ENDED	PERSON WHO RECEIVES ASSISTANCE
CHILD SUPPORT/ALIMONY				
UNEMPLOYMENT				
SOCIAL SECURITY				
SSI / SSD				
EDUCATION SOURCE: PERIOD COVERED:				
GRANTS				
VETERANS' BENEFITS				
INDIAN GENERAL ASST.				
DISABILITY PAYMENTS				
RETIREMENT PENSION				
INTEREST (STOCKS, BONDS, ETC.)				
RENTAL INCOME				
BOARDERS/ROOMERS				
LOW INCOME HOUSING ASSISTANCE				
TANF				
MONEY FROM FAMILY/FRIENDS				

Do you receive any income not listed from the sources above? ☐ YES ☐ NO

If yes, please explain: _____

OTHER ASSETS OR RESOURCES

Do you or any member of the household have any of the following resources or an authorized signer on any of the following?

TYPE OF ASSET / RESOURCE	DESCRIPTION / ACCOUNT NUMBER	VALUE	HOUSEHOLD MEMBER ASSOCIATED WITH ASSET
CASH			
ALL CHECKING ACCOUNTS			
ALL SAVINGS ACCOUNTS			
ALL TRUST ACCOUNTS			
SAFE DEPOSIT BOX			
SAVINGS BONDS			
STOCKS			
TIME CERTIFICATES			
IRA,KEOGH, RETIREMENT			
FUNERAL PLAN/LIFE INS.			
PATIENT TRUST FUND			
MINERAL, OIL OR MINING CLAIMS			
OTHER			

VEHICLES

Please list any vehicles, motorcycles, trailers, campers, boats, motor homes, or all-terrain vehicles you or any member of your household own or are in the process of purchasing:

REGISTERED OWNER	MAKE / MODEL / YEAR	VALUE	AMOUNT OWED

REAL PROPERTY

Is any member of the household purchasing property? ☐ YES ☐ NO

If yes, please answer the following:

Owner: _____ Location: _____

Value: _____ Amount Owed: _____

Sold any property in the last 3 years? ☐ YES ☐ NO If yes, describe : _____

Does any member of the household own business equipment, machinery or inventory? ☐ YES ☐ NO

If yes, please describe: _____ Value: _____ Amt. Owed: _____

Is this equipment/property used for to earn money? ☐ YES ☐ NO

Does any member of the household own or lease livestock? ☐ YES ☐ NO

MONTHLY EXPENSES

EXPENSE	COMPANY / PAYEE	MONTHLY AMOUNT
ALIMONY / CHILD SUPPORT		
CABLE / SATELLITE		
VEHICLE PAYMENT		
CHILD CARE		
CREDIT CARDS		
ELECTRICITY		
GARBAGE / TRASH REMOVAL		
GASOLINE		
GROCERIES		
HEATING (GAS, PROPANE)		
INSURANCE		
MEDICAL EXPENSES		
MORTGAGE / RENT		
SPACE / LOT RENT		
TELEPHONE OR CELL PHONE		
WATER / SEWER		
PROPERTY TAX		
OTHER		

If you live with someone and they pay household bills, please include them in the above section. This amount will be divided by the number of household members to determine an in-kind amount.

MEDICAL ONLY (COMPLETE IF APPLYING FOR ASSISTED LIVING)

Please complete the information below for any hospital, medical, dental, vision, prescription, or accident coverage you have through yourself or anyone else including past employers or union. Please provide proof of each coverage.

Insured name: _____ Insurance Company: _____

Policy #: _____ Group #: _____

What kind of coverage? _____ Effective Date: _____

Premium amount: _____ Paid how often? _____

AUTHORIZED REPRESENTATIVE

Do you want someone other than yourself to act on your behalf or have access to your information as it pertains to assistance through Elko County? ☐ YES ☐ NO

If yes, who? _____ Phone number: _____

SIGNATURE AND AFFIRMATION

I agree to furnish any information Elko County Human Services may require with respect to this application. I further agree to notify Elko County Human Services of:

- Any changes in my circumstances.
- Any real or personal property transactions.
- Change in income or other financial conditions.
- Change in employment status of any member of the household.
- Marriage of any of the children, ore remarriage of either parent of the children.
- Any change of personal information, include address, phone, or e-mail information.
- If a parent is absent from the home, any information regarding his/her whereabouts or return to the home.
- Any other information that may affect my application for assistance.

I understand that failure to comply constitutes an act of fraud. I solemnly swear or affirm that the statements made within this application are true and correct to the best of my knowledge.

I understand that Elko County has **30 days from the date my application and all supporting documentation is received** in order to make a decision.

Applicant Signature

Date

Co-applicant Signature

Date

AUTHORIZATION TO FURNISH INFORMATION / RELEASE OF LIABILITY

I hereby authorize Elko County Human Services to make any investigation concerning me, other members of my household, which may be necessary to determine eligibility for any benefit. I have received or may receive under programs administered by this agency. I hereby authorize and consent to the release of any and all information concerning me, or any household members to Elko County Human Services by the holder of the information, regardless of the manner of form held, including, without limitation, information made confidential by law or otherwise and patient information privileged under NRS 49.225 or any other provision of law or otherwise. I hereby release the holder of such information from liability, if any, resulting from the disclosure of required information. Additionally, I authorize the agency to contact my employer(s) to obtain wage information. A reproduced copy of this application and authorization legally constitutes an original copy.

Applicant Signature

Date

Co-applicant Signature

Date

REIMBURSEMENT AGREEMENT

Although financially unable to provide for my needs such as rent, medical, or utilities at this time, I request that Elko County provide assistance, and I agree to reimburse the County in monthly installments as agreed upon by myself and Elko County Human Services.

While reimbursement is not always required, repayment of these services will enable additional individuals and families to be served.

Applicant Signature

Date

Co-applicant Signature

Date



Elko County Social Services
Mailing 571 Idaho St.-Elko, NV 89801
Physical 540 Court St.-Elko, NV 89801
Phone (775) 738-4375 Ext. 2
Fax (775) 738-5984

INCOME VERIFICATION REQUEST
Must be completed by Employer

Employer

Employee Name

Address

Social Security Number

I HEREBY AUTHORIZE YOU TO RELEASE TO ELKO COUNTY SOCIAL SERVICES THE FOLLOWING INFORMATION.

Employee Signature

Date

ATTENTION PAYROLL DEPARTMENT:

Please complete the bottom portion of this form and return it to the above address. Your cooperation will help insure and maintain accountability in the administration of public funds in Nevada. The information provided to us will be used in conjunction with the official duties of this department and is considered confidential.

EMPLOYEES JOB TITLE: _____

Date Employee Started: _____ Date of first paycheck: _____ Hours per week: _____ Hourly Wage: _____

GROSS WAGES FOR LAST 60 DAYS:

_____	\$ _____	_____	\$ _____	_____	\$ _____
Date	Amount	Date	Amount	Date	Amount
_____	\$ _____	_____	\$ _____	_____	\$ _____
Date	Amount	Date	Amount	Date	Amount

Tips received estimated amount per pay period? \$ _____

❖ **PLEASE COMPLETE THE FOLLOWING IF THIS EMPLOYEE IS NO LONGER EMPLOYED**

Released: _____ Date: _____ Reason: _____

Quit: _____ Date: _____ Reason: _____

Employer or Payroll Manager

Date

Phone

Josefina Barron, Eligibility Specialist



**ELKO COUNTY
HUMAN SERVICES**

571 Idaho Street
Elko, NV 89801
775.738.4375

RESIDENCE VERIFICATION FORM

TO BE COMPLETED BY LANDLORD

By completing this form, you are verifying that the client is currently residing in your rental property or will be residing in your rental property.

TENANT NAME _____ RENTAL ADDRESS _____

LANDLORD NAME _____ LANDLORD ADDRESS/PHONE NUMBER _____

Type of rental property (please mark the appropriate box – ownership will be verified)

☐ Private Residence

☐ Managed Facility

Name of Facility _____

If client is a new tenant, please complete this section:

Move-In Date _____

Monthly Rent Amount: _____

If client is currently residing in your rental property, please complete this section:

Move-In Date: _____

Monthly Rent Amount: _____

Is rent paid to date? **YES** **NO**

If no, amount due: _____

TO BE COMPLETED BY TENTANT/CLIENT

Please list all other individuals who are currently residing or will be residing in the rental residence:

TO BE COMPLETED BY LANDLORD

By initialing each of the following items, I understand:

Landlord/Tenant

_____/_____

Completion of this form only verifies a residence is available or that the client is currently residing in the residence.

_____/_____

Rental assistance has not yet been approved – approval may take 30 days.

_____/_____

Only one month of assistance may be approved, not to exceed \$750.

_____/_____

Elko County does not provide deposit assistance.

_____/_____

Elko County cannot provide assistance if the client's rent is more than one month past due after payment by Elko County. If client is more than one month past due, a voucher will not be issued until the client pays the balance due. If the balance cannot be paid in full before the date provided by Elko County, assistance will not be provided.

Client/Tenant Signature _____

Date _____

Landlord Signature _____

Date _____

Detailed Notice of Privacy Practices

IMPORTANT: 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.

Elko County Social Services is committed to protecting your personal health information. We are required by law to maintain the privacy of health information that could reasonably be used to identify you, known as "protected health information" or "PHI." We are also required by law to provide you with the attached detailed Notice of Privacy Practices ("Notice") explaining our legal duties and privacy practices with respect to your PHI.

We respect your privacy, and treat all healthcare information about our patients with care under strict policies of confidentiality that our staff is committed to following at all times.

PLEASE READ THE ATTACHED DETAILED NOTICE. IF YOU HAVE ANY QUESTIONS ABOUT IT, PLEASE CONTACT

***Kathy Jones,
Social Services Director, at 775-738-4375 or kjones@elkocountynv.net.***

Purpose of This Notice: This Notice describes your legal rights, advises you of our privacy practices, and lets you know how Elko County Ambulance Service is permitted to use and disclose PHI about you.

Uses and Disclosures of Your PHI We Can Make Without Your Authorization

Elko County Social Services may use or disclose your PHI *without* your authorization, or *without* providing you with an opportunity to object, *for the following purposes:*

Treatment. This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other healthcare personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.

Payment. This includes any activities we must undertake in order to get reimbursed for the services that we provide to you, including such things as organizing your PHI, submitting bills to insurance companies (either directly or through a third party billing company), managing billed claims for services rendered, performing medical necessity determinations and reviews, performing utilization reviews, and collecting outstanding accounts.

Healthcare Operations. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes, fundraising, and certain marketing activities.

Other Uses and Disclosure of Your PHI We Can Make Without Authorization.

Elko County Social Services is also permitted to use or disclose your PHI *without* your written authorization in situations including:

For the treatment activities of another healthcare provider;

To another healthcare provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company);

ELKO COUNTY SOCIAL SERVICES

Notice of Privacy Practices

Uses and Disclosures of Your PHI That Require Your Written Consent

Any other use or disclosure of PHI, other than those listed above, will only be made with your written authorization (the authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it). Specifically, we must obtain your written authorization before using or disclosing your: (a) psychotherapy notes, other than for the purpose of carrying out our own treatment, payment or health care operations purposes, (b) PHI for marketing when we receive payment to make a marketing communication; or (c) PHI when engaging in a sale of your PHI. **You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.**

Your Rights Regarding Your PHI

As a patient, you have a number of rights with respect to your PHI, including:

Right to access, copy or inspect your PHI. You have the right to inspect and copy most of the medical information that we collect and maintain about you. Requests for access to your PHI should be made in writing to Elko County Social Services Department. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have available forms to request access to your PHI, and we will provide a written response if we deny you access and let you know your appeal rights.

We will normally provide you with access to this information within 30 days of your written request. If we maintain your medical information in electronic format, then you have a right to obtain a copy of that information in an electronic format. In addition, if you request that we transmit a copy of your PHI directly to another person, we will do so provided your request is in writing, signed by you (or your representative), and you clearly identify the designated person and where to send the copy of your PHI.

Right to request an amendment of your PHI. You have the right to ask us to amend protected health information that we maintain about you. Requests for amendments to your PHI should be made in writing and you should contact Amanda Osborne, Social Services Director if you wish to make a request for amendment and fill out an amendment request form.

When required by law to do so, we will amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information in certain circumstances, such as when we believe that the information you have asked us to amend is correct.

Right to request an accounting of uses and disclosures of your PHI. You may request an accounting from us of disclosures of your medical information. If you wish to request an accounting of disclosures of your PHI that are subject to the accounting requirement, you should contact Amanda Osborne, Social Services Director and make a request in writing.

You have the right to receive an accounting of certain disclosures of your PHI made within six (6) years immediately preceding your request. But, we are not required to provide you with an accounting of disclosures of your PHI: (a) for purposes of treatment, payment, or healthcare operations; (b) for disclosures that you expressly authorized; (c) disclosures made to you, your family or friends, or (d) for disclosures made for law enforcement or certain other governmental purposes.

Right to request restrictions on uses and disclosures of your PHI. You have the right to request that we restrict how we use and disclose your medical information for treatment, payment or healthcare operations purposes, or to restrict the information that is provided to family, friends and other individuals involved in your healthcare. However, we are only required to abide by a requested restriction under limited circumstances, and it is generally our policy that we will not agree to any restrictions unless required by law to do so. If you wish to request a restriction on the use or disclosure of your PHI, you should contact Amanda Osborne, Social Services Director and make a request in writing.

A restriction may be terminated if you agree to or request the termination. Most current restrictions may also be terminated by Elko County Ambulance Service as long we notify you. If so, PHI that is created or received after the restriction is terminated is no longer subject to the restriction. But, PHI that was restricted prior to the notice to you voiding the restriction must continue to be treated as restricted PHI.

Right to notice of a breach of unsecured protected health information. If we discover that there has been a breach of your unsecured PHI, we will notify you about that breach by first-class mail dispatched to the most recent address that we have on file. If you prefer to be notified about breaches by electronic mail, please contact Amanda Osborne, Social Services Director, to make Elko County Ambulance Service aware of this preference and to provide a valid email address to send the electronic notice. You may withdraw your agreement to receive notice by email at any time by contacting Amanda Osborne, Social Services Director.

Right to request confidential communications. You have the right to request that we send your PHI to an alternate location (*e.g.*, somewhere other than your home address) or in a specific manner (*e.g.*, by email rather than regular mail). However, we will only comply with reasonable requests when required by law to do so. If you wish to request that we communicate PHI to a specific location or in a specific format, you should contact Amanda Osborne, Social Services Director and make a request in writing.

Internet, Email and the Right to Obtain Copy of Paper Notice

If we maintain a web site, we will prominently post a copy of this Notice on our web site and make the Notice available electronically through the web site. If you allow us, we will forward you this Notice by electronic mail instead of on paper and you may always request a paper copy of the Notice.

Revisions to the Notice

Elko County Social Services is required to abide by the terms of the version of this Notice currently in effect. However, Elko County Social Services reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all PHI that we maintain. Any material changes to the Notice will be promptly posted in our facilities and on our web site, if we maintain one. You can get a copy of the latest version of this Notice by contacting Amanda Osborne, Social Services Director.

To another healthcare provider (such as the hospital to which you are transported) for the healthcare operations activities of the entity that receives the information as long as the entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;

For healthcare fraud and abuse detection or for activities related to compliance with the law;

To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family, relatives, or friends if we infer from the circumstances that you would not object. For example, we may assume that you agree to our disclosure of your personal health information to your spouse when your spouse has called the ambulance for you. In situations where you are incapable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to your family member, relative, or friend is in your best interest. In that

situation, we will disclose only health information relevant to that person's involvement in your care. For example, we may inform the person who accompanied you in the ambulance that you have certain symptoms and we may give that person an update on your vital signs and treatment that is being administered by our ambulance crew;

To a public health authority in certain situations (such as reporting a birth, death or disease, as required by law), as part of a public health investigation, to report child or adult abuse, neglect or domestic violence, to report adverse events such as product defects, or to notify a person about exposure to a possible communicable disease, as required by law;

For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the healthcare system;

For judicial and administrative proceedings, as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;

For law enforcement activities in limited situations, such as when there is a warrant for the request, or when the information is needed to locate a suspect or stop a crime;

For military, national defense and security and other special government functions;

To avert a serious threat to the health and safety of a person or the public at large;

For workers' compensation purposes, and in compliance with workers' compensation laws;

To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;

If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ donation and transplantation; and

For research projects, but this will be subject to strict oversight and approvals and health information will be released only when there is a minimal risk to your privacy and adequate safeguards are in place in accordance with the law.

Your Legal Rights and Complaints

You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services, if you believe that your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government.

Should you have any questions, comments or complaints, you may direct all inquiries to Amanda Osborne, Social Services Director. Individuals will not be retaliated against for filing a complaint.

If you have any questions or if you wish to file a complaint or exercise any rights listed in this Notice, please contact:

Kathy Jones, Elko County Public Guardian
Elko County Social Services
540 Court St.
Elko, NV 89801
775-738-4375
kjones@elkocountynv.net

Effective Date of the Notice: 02/22/2018