nystateofhealth
The Official Health Plan Marketplace

Janet Smith
123 New Ave 2G
New City, NY 10001

All decisions described in this notice are based on information about you from state and federal data sources obtained as of September 15, 2018.

September 16, 2018
Account ID: AC0000000123

Help at: 1-855-355-5777
TTY: 1-800-662-1220

# Important Notice About Your Health Insurance Coverage

It's time for you and/or members of your household to renew your health insurance coverage through NY State of Health, The Official Health Plan Marketplace. This letter contains important information about renewing your health insurance coverage.

## It is renewal time and NO ACTION IS REQUIRED for the following individuals:

**Janet Smith(AB12345C)** **Marketplace ID:**HX0000000123

| | |
|---|---|
| **NO CHANGE IN ELIGIBILITY:** | You qualify for **Medicaid**, effective **November 1, 2018**. |
| **INSURANCE DETAILS:** | **Insurance Company:** Fidelis Care<br>**Program:** Medicaid<br>**Start Date:** November 1, 2018 |
| **NO ACTION REQUIRED:** | Your health insurance coverage has not changed. We re-enrolled you into the same product that you had before. Contact your insurance company if you have questions about covered services or providers.<br><br>If you want to make a change, you must do so between **September 16, 2018** and **October 15, 2018**. See the section of this notice,*"How and When to Make Changes to Your Account or Coverage".* |

**Call NY State of Health at 1-855-355-5777 (TTY: 1-800-662-1220) to get help in other languages or for help reading this notice. This notice is also available in other formats. Call for more information. To find a navigator or certified application assistor near you, visit https://www.nystateofhealth.ny.gov or call us.**

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## Find Health Insurance Coverage Information Through NY State of Health

To find helpful information about health insurance, including how it works, how to use it, how to find a doctor, and the meaning of insurance terms, go to: http://info.nystateofhealth.ny.gov/UsingYourInsurance.

## How and When to Make Changes to Your Account or Coverage

Follow the steps below –

IF ... NY State of Health has requested that you complete the renewal process by updating some information (for example, pick a health plan or update information in your application);

IF ... Anything has changed in your life that may affect your health insurance coverage or financial assistance;

IF ... You are enrolled in a plan and want to see if you have other coverage options.

**Step 1.** Go to www.nystateofhealth.ny.gov and log into your account.

OR

Contact a Navigator or Certified Application Counselor. These individuals, located at community-based organizations and health plans, are trained to help you understand your health insurance coverage options and enroll in coverage. If you are already enrolled in coverage, you can also call your health plan for assistance.

**Step 2.** Make changes for you and/or your household members. You need to make the changes between **September 16, 2018** and **October 15, 2018** to see what you qualify for on **November 1, 2018**.

Below are some of the events in your life or a household member's life that could affect what health insurance coverage you are re-enrolled in, who is covered, or how much you pay. Tell us if:

- You move
- Your income changes (only if you are receiving financial assistance)
- You get access to or enroll in the New York State Health Insurance Program (NYSHIP)
- Your eligibility for health insurance from a job changes
- The cost of your health insurance premium from a job changes
- Your household changes. For example, you marry/divorce, become pregnant, or have a child; adopt a child, or a child is placed for adoption with you
- You become qualified for other health insurance



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- There is a change in full-time student status (if applicable to application members)
- There is a change in immigration status
- You change how you plan to file your taxes. For example, you will claim new dependents (only if you are receiving financial assistance)

If you do not report changes within 30 days and they affect your ability to get government help with insurance costs, you may have to pay back some or all of the subsidies you received.

## What Happens After You Make Changes to Your Account

You will receive a notice from NY State of Health with information about your new health insurance coverage and any financial assistance you will receive.

## NOTE – For individuals enrolled in a health plan with a monthly premium:

Any failure to pay your premium may result in cancellation of next year's plan enrollment. If you still qualify for health insurance coverage but received a notice from NY State of Health that states your current year of coverage ended because you did not pay your premium, you must go to www.nystateofhealth.ny.gov to pick a plan for next year.

## How We Made Our Decision

**Janet Smith(AB12345C)** **Marketplace ID:** HX0000000123

You qualify for Medicaid because federal and state data sources show that your income is between $0 and $16,754.00.

This is the allowable income range for Medicaid based on your household size.

## About Medicaid Managed Care

**Next Steps for health plan enrollment in Medicaid:**

If you are eligible to enroll in a Medicaid Managed Care plan and are not yet enrolled in one, you need to choose a health plan. If you do not choose a plan, one will be chosen for you. If you need health care before your health plan coverage begins, use your Medicaid card at any health provider who takes Medicaid.

- Your new health plan card will come in the mail.

- If you are enrolled in a Medicaid Managed Care plan, you will get two cards – a New York State Benefit Identification card (Medicaid card) and a card from your health plan. Keep your health plan card and Medicaid card in a safe place; you will need both.

- You must use Medicaid providers and show your Medicaid card to receive any Medicaid services that are not covered by your Managed Care plan.

- You will receive information about your benefits and available providers in your network from your plan. The benefit package will cover a wide range of services, including doctor's visits, inpatient hospital care, lab tests, prescription and non-prescription drugs and much more. For any questions about your health plan's covered services and providers, you may contact your health plan directly.

- You should contact your new health plan to select your Primary Care Provider (PCP). If you are choosing a new doctor, call the doctor's office first to make sure that he or she is accepting new patients and is participating in the health plan you have selected.

- You may have the opportunity to opt out of enrolling into a Medicaid Managed Care plan. Some people have a special situation that allows them to choose to either join a health plan or to receive regular (fee-for-service) Medicaid. This includes Native Americans, and people in waivered programs such as Care At Home and Traumatic Brain Injury (TBI). If you think you may have one of these special situations, or would like to learn more about your options, you may call NY State of Health.

- You may be eligible to select and enroll in a Special Needs Plan (SNP) if you are a New York City health plan member. SNPs, with their own set of doctors, providers, and hospitals, are designed to meet the specialized health needs of individuals who are homeless, transgender, or living with HIV/AIDS. *Medicaid members who are eligible for SNP may transfer to these plans at any time.*

- You may be eligible to select and enroll in a Health and Recovery Plan (HARP) for adults who need physical and/or behavioral health services. HARPs provide services such as doctor visits, mental health and substance use disorder services, medications, and hospital care. *Medicaid members who are eligible for HARP may transfer to these plans at any time.*

- Persons eligible for HARP or SNP can transfer into these plans at any time. For persons eligible for all other plans, you will have 90 days from the effective date of your health plan enrollment to change your plan for any reason. You can only change plans if there is another health plan available in your area. After 90 days, you will not be able to change your health plan for the next 9 months, unless you have a good reason. For more information about this, contact NY State of Health.

## How to Use Your State Benefit Identification Card (Medicaid Card)

**Important information about your New York State Benefit Identification card (Medicaid card):**

If you are new to the Medicaid program, you will receive a New York State Benefit Identification card (Medicaid card) in the mail. If you received Medicaid benefits in the past and were issued a card at that time, you should use that card. Please call NY State of Health at 1-855-355-5777 if you do not get your card or cannot find your old card.

You must bring your card with you each time you use medical services. Please keep your card in a safe place and let us know immediately if your card does not work, is lost or stolen. Keep this card even if you stop receiving benefits. The same card may be used again if you become eligible in the future.

If you need medical care before you receive your card, you must make sure the provider accepts Medicaid. The Medicaid program can only pay the bill for medical services if the provider accepts Medicaid.

For more information on what services are covered by Medicaid or to find a Medicaid provider near you, please call the Medicaid Helpline at 1-800-541-2831.

## If You Think We Made a Mistake

If you think we made a mistake about your eligibility, you can call us to discuss your concerns. Call NY State of Health at 1-855-355-5777 (TTY: 1-800-662-1220).

Decisions you can appeal

- Decision that you do not qualify to buy a health plan for yourself or your family through NY State of Health.
- Decision that you do not qualify for federal help paying for a health plan purchased through NY State of Health.
- Decision on how much you must pay for your monthly premium if you applied for financial help.
- Decision that you do not qualify for Medicaid or Child Health Plus.
- Decision on how much money you must pay for Child Health Plus coverage if your children are eligible for this program.
- Decision that you do not meet the rules for signing up for insurance through NY State of Health during a "special enrollment period."

You will find more information on how to ask for an appeal in the "How to Request an Appeal and Additional Information" section at the end of this notice.

## How to Contact NY State of Health

Contact us if you have any questions about this Notice. Let us know if you need help applying for or accessing your health insurance coverage.

**Call**: 1-855-355-5777 (TTY: 1-800-662-1220)
**Mail**: NY State of Health
PO Box 11727
Albany, NY 12211

**Legal Reference:**

Listed below are the specific laws and government regulations which give NY State of Health the authority and which set the rules under which we can offer affordable health insurance to New York State residents.

This decision is based on Section 366(1)(b) of the Social Services Law.

We determined your projected eligibility in accordance with 45 CFR §155.335.

Applicant has the right to appeal an eligibility determination pursuant to 45 CFR §155.355 and 155.505(b).

This decision is based on Section 369-gg of the Social Services Law.

We are sending you this notice based on federal regulation 45 CFR §155.310(g).

We are sending you this notice as required by 42 CFR 600.330(e).

Eligibility standards for enrollment through NY State of Health may be found at 45 CFR §155.305.

This decision is based on Section 364-j of the Social Services Law.

## How to File an Appeal and Additional Information

An appeal is your request to NY State of Health to review and change a decision we have made about your eligibility.

### How and When to Ask for an Appeal

You can request an appeal by doing one of these things:

- Call us at 1-855-355-5777 (TTY: 1-800-662-1220).
- Mail your request to: NY State of Health, PO Box 11729, Albany, NY 12211.
- Fax your request to 1-855-900-5557.

You have 60 calendar days from the date on this notice to ask for an appeal. You will receive a letter from NY State of Health saying that we received your request. We will send you a letter telling you the date and time of your appeal hearing.

### Asking for Aid to Continue

You can ask for Aid to Continue to keep your current coverage while you go through the appeals process. You must ask for this when you ask for an appeal. This means that your current insurance program will continue until a decision is made about your appeal.

If you have Medicaid coverage, we will continue your coverage if you request Aid to Continue within 10 days from the date of this notice OR before the eligibility effective date listed in this notice, whichever is later.

### The Appeal Hearing

The hearing is your chance to explain why you disagree with the NY State of Health's decision. A hearing officer will make a decision about your appeal. The hearing officer will not take sides and will not favor you or NY State of Health. The officer will conduct the hearing by phone. Here is what you need to do before, during, and after the hearing.

*Before the hearing*

- Look at the documents NY State of Health used to make a decision about your eligibility.
- You can send us information that might help us understand your appeal.
- You can request specific policy materials necessary to help you decide whether to ask for an appeal or to help you prepare for your appeal hearing.
- We may try to resolve your issues through an informal dispute resolution process.

*During the hearing*

- You can have someone with you during your telephone hearing if you want to. That person can be a friend, relative, lawyer, or other individual. Or you can participate in your hearing on your own.

*After the hearing*

- The outcome of an appeal could change the eligibility of other people on your account even if they do not ask for an appeal.

- If the appeal is not resolved in your favor, you may be responsible for the cost of the health coverage that you used while your appeal was being processed. Here are some examples of what you may have to do when the appeal is not resolved in your favor:

    - If you received coverage through Medicaid while your appeal is being determined, you may have to pay back the cost of Medicaid benefits you received.

    - If you were enrolled in the Essential Plan or Child Health Plus while your appeal was being determined, you may have to pay back your premium, if you have a premium.

    - If your appeal found that you are not qualified for tax credits, the IRS will reconcile your tax credits when you file your federal tax return, which may result in a tax penalty.

## HIPAA Privacy Notice

New York State is committed to protecting your privacy. To learn more about NY State of Health's privacy practices go to www.nystateofhealth.ny.gov or call customer service at 1-855-355-5777 (TTY: 1-800-662-1220).

## Notice of Nondiscrimination Policy

NY State of Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age or disability in its health program and activities.

NY State of Health also complies with applicable state laws and does not discriminate on the basis of race, color, national origin, creed/religion, sex, marital/family status, disability, arrest record, criminal conviction(s), gender identity, sexual orientation, predisposing genetic characteristics, military status, domestic violence victim status and/or retaliation.

NY State of Health:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- TTY through NY Relay Service

- Written information in other formats such as large print, audio, accessible electronic formats and other formats

Provides free language assistance services to people whose primary language is not English, such as:

- Qualified interpreters
- Written information in other languages

If you need these services or for more information, contact 1-855-355-5777 (TTY 1-800-662-1220).

If you believe that NY State of Health has discriminated against you, you may file a complaint by going to: http://www.health.ny.gov/regulations/discrimination_complaints/ or by emailing the Diversity Management Office at DMO@health.ny.gov.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 800-368-1019 (TTY 800-537-7697). Complaint forms are available at https://hhs.gov/ocr/office/file/index.html.

## Register to Vote

If you are not registered to vote where you live now and would like to register, you can do so:

- Online at the New York State DMV voter registration page http://dmv.ny.gov/more-info/electronic-voter-registration-application.
- By completing the New York State Agency voter registration form included with this notice and mailing it back to us.

**Important Information to Know**

- Applying to register or declining to register to vote will **not** affect your eligibility or the assistance you will be provided by NY State of Health.
- If you would like help in filling out the voter registration application form or to request a paper voter registration application form, we will help you. For help, contact customer service at 1-855-355-5777 (TTY: 1-800-662-1220). The decision whether to seek or accept help is yours. You may fill out the application form in private.

- If you believe that someone has interfered with your right to register or decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

NYS Board of Elections
40 North Pearl St., Suite 5
Albany, NY 12207-2729
Telephone: 1-800-469-6872;
TDD/TTY users contact the New York State Relay at 711;
or visit the website - www.elections.ny.gov



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# NYS Agency-Based Voter Registration Form

"If you are not registered to vote where you live now, would you like to apply to register here today?"

- ☐ **YES** (If you check yes, please complete VOTER REGISTRATION APPLICATION at bottom of page)
- ☐ NO because I choose not to register OR
- ☐ I am already registered at my current address OR
- ☐ I asked for and received a mail registration form.

**If you do not check any box, you will be considered to have decided not to register to vote at this time.**

_____ ____/____/____
(Signature) (Date)

_____
(Please Print Name)

## Important!

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

Información en español: si le interesa obtener este formulario en español, llame al 1-800-367-8683

中文資料:若您有興趣索取中文資料表格,請電: 1-800-367-8683

한국어: 한국어 양식을 원하시면 1-800-367-8683 으로 전화 하십시오.

যদি আপনি এই ফরমটি বাংলাতে পেতে চান তাহলে 1-800-367-8683 নম্বরে ফোন করুন

## VOTER REGISTRATION APPLICATION (instructions on back)

NVRA-05 (01/2011)

☐ Yes, I need an application for an Absentee Ballot **Please print or type in blue or black ink** ☐ Yes, I would like to be an Election Day worker

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **1** | Are you a U.S. citizen? Yes ☐ No ☐ If you answered NO, do not complete this form. | **2** | Will you be 18 years old on or before election day? Yes ☐ No ☐ If you answered NO, do not complete this form unless you will be 18 by the end of the year. | | | | **For Board use only!** |
| **3** | Last Name | First Name | | Middle Name | Suffix | | |
| **4** | Address where you live (do not give P.O. address) | Apt. No. | City/Town/Village | | Zip Code | County | |
| **5** | Address where you get your mail (if different from above) | P.O. Box, star route, etc. | | Post Office | | Zip Code | |
| **6** | Date of Birth | **7** | Sex (Circle) M F | **8** | Home Tel. Number (optional) | | |
| **10** | The last year you voted | Your Address was (give house number, street and city) | | | | **9** | ID Number - Check the applicable box and provide your number: ☐ New York DMV number __ __ __ __ __ __ __ __ __ If you do not have a New York DMV number, please provide: ☐ Last four digits of your Social Security Number __ __ __ __ ☐ I do not have a New York Driver's license number |
| | In county/state | Under the Name (if different from your name now) | | | | | |

**11** **Choose a party** -- Check one box only

- ☐ Democratic Party
- ☐ Republican Party
- ☐ Conservative Party
- ☐ Working Families Party
- ☐ Independence Party
- ☐ Green Party
- ☐ Other (write in) _____
- ☐ I do not wish to enroll in a party

**12** **AFFIDAVIT:** I swear or affirm that

- I am a citizen of the United States.
- I will have lived in the county, city or village for at least 30 days before the election.
- I will meet all requirements to register to vote in New York State.
- This is my signature or mark on the line below.
- The above information is true, I understand that if it is not true, I can be convicted and fined up to $5,000 and/or jailed for up to four years.

→ _____
(Signature or Mark in Ink) (Date)

## (Optional) Register to donate your organs and tissues

Last Name_____
First Name_____
Middle Initial_____ Suffix_____
Address_____
Apt Number_____ Zip Code_____
City_____
Birth Date_____ Sex ☐ M ☐ F
Eye Color_____ Height___ Ft. ___In.

By signing below, you certify that you are:

- 18 years of age or older
- Consent to donate all of your organs and tissues for transplantation, research, or both;
- Authorizing the Board of Elections to provide your name and identifying information to DOH for enrollment in the Registry;
- And authorizing DOH to allow access to this information to federally regulated organ procurement organizations and NYS-licensed tissue and eye banks and hospitals upon your death.

_____
Sign Date

Qualifications for Registration

You Can Use This Form To:

- register to vote in New York State;
- change your name and/or address, if there is a change since you last voted;
- enroll in a political party or change your enrollment.

To Register You Must:

- be a U.S. citizen;
- be 18 years old by December 31 of the year in which you file this form (note: You must be 18 years old by the date of the general, primary, or other election in which you want to vote.);
- be a resident of the County, or of the City of New York at least 30 days before an election;
- not be in jail or on parole for a felony conviction; and
- not claim the right to vote elsewhere.

**Important!**

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

New York State Board of Elections, 40 Steuben Street,
Albany, New York 12207-2109
Telephone: 1-800-469-6872;
TDD/TTY users contact the New York State Relay at 711;
or visit our web site - www.elections.state.ny.us

Your decision to register will remain confidential and will be used only for voter registration purposes. Anyone not choosing to register to vote and/or information regarding the office to which the application was submitted will remain confidential, to be used only for voter registration purposes.

# Verifying your identity

We will try to check your identity before Election Day, through the **DMV number (driver's license number or non-driver ID number)**, or the **last four digits of your social security number, which you will fill in Box 9.**

**If you do not have a DMV or Social Security number**, you may use a valid photo ID, a current utility bill, bank statement, pay-check, government check or some other government document that shows your name and address. You may include a copy of one of those types of ID with this form.

**If we are unable to verify your identity before Election Day, you will be asked for ID when you vote for the first time.**

# To complete this form:

**It is a crime to procure a false registration or to furnish false information to the Board of Elections.**

Box 9: You must make one selection. For questions refer to Verifying your identity above.

Box 10: If you have never voted before, write "None". If you can't remember when you last voted, put a question mark(?). If you voted before under a different name, put down that name. If not, write "Same".

Box 11: Check one box only. To vote in a primary election, you must be enrolled in one of these listed parties - Except the Independence Party, which permits non-enrolled voters to participate in certain primary elections.

# Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

**Español (Spanish)**

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

**中文 (Traditional Chinese)**

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

**Kreyòl Ayisyen (Haitian Creole)**

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

**中文 (Simplified Chinese)**

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

**Italiano (Italian)**

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

**한국어 (Korean)**

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

**Русский (Russian)**

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

**العربية (Arabic)**

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

**বাংলা (Bengali)**

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

**Français (French)**

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

**हिंदी (Hindi)**

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

**日本語 (Japanese)**

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

**नेपाली (Nepali)**

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं।

**Polski (Polish)**

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

**Twi (Twi)**

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

**اردو (Urdu)**

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

**Tiếng Việt (Vietnamese)**

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

**אידיש (Yiddish)**

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.