STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: March 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013029

[redacted]

Dear [redacted]

On February 17, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 30, 2016 and October 8, 2016 eligibility determination notices.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the Account ID at the top of this notice.

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: March 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013029

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health (NYSOH) properly determine that your eligibility for advance payments of the premium tax credit (APTC) began on November 1, 2016?
>
> Did NYSOH properly determine that you were not eligible for Medicaid in the month of July 2016?

Procedural History

On December 11, 2015, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in an Essential Plan with a $20.00 monthly premium, effective January 1, 2016.

On December 15, 2015, NYSOH issued a notice of enrollment confirmation confirming your enrollment in an Excellus Essential Plan with a $20.00 per month premium effective January 1, 2016.

On July 2, 2016, NYSOH issued a disenrollment notice stating that your enrollment in your Excellus Essential Plan was terminated, effective June 30, 2016, because a premium payment had not been received by Excellus.

On July 8, 10, and 13, 2016, you updated your NYSOH account and attempted to reenroll in coverage and to reapply for financial assistance with health insurance.

On September 29, 2016, you updated your NYSOH account and requested help paying for medical bills from July and August 2016.

On September 30, 2016, NYSOH issued a notice of eligibility determination stating that you were not eligible for help with paying for medical bills for the months of July and August 2016 because the program you were eligible for cannot pay for any care received in the past.

On October 7, 2016, NYSOH issued an eligibility determination, based on the information in your July 13, 2016 application, stating that you were eligible for the Essential Plan, effective November 1, 2016.

On October 8, 2016, NYSOH issued an eligibility determination, based on the information in your September 29, 2016 application, stating that you were eligible to receive up to $278.00 per month in APTC, shared with your son, effective November 1, 2016.

On November 2, 2016, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination notices insofar as they began your eligibility for enrollment in a qualified health plan with APTC on November 1, 2016, and not July 1, 2016.

On November 15, 2016, your NYSOH account was updated again.

On November 16, 2016, NYSOH issued a notice of eligibility determination stating that you and your two sons were eligible to receive up to $343.00 per month in APTC, effective December 1, 2016.

Also on November 16, 2016, NYSOH issued a notice of enrollment confirmation stating that you and your two sons were enrolled in a silver level qualified health plan, effective November 1, 2016, with the application of your APTC to your monthly premium to begin as of December 1, 2016.

On February 17, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open for fifteen days at the end of the hearing to allow you time to submit proof of your Essential Plan premium payments, and proof of your income in the month of July 2016. On March 3, 2017, you uploaded documentation to your NYSOH account. The record is now closed.

Findings of Fact

A review of the record support the following findings of fact:

1) Your NYSOH account reflects that you were enrolled in Essential Plan coverage through June 30, 2016, at which point your coverage was terminated due to alleged nonpayment of premiums.

2) You testified that you always made your premium payments online, and that you generally paid for the current month and the following month at the same time.

3) You testified that the Excellus website was down from the middle of June until the end of June 2016, and that you were unable to make a payment.

4) You testified that you went to the website several times to try to pay your June and July 2016 premiums, but could not get into your account.

5) You testified that you decided to pay by check instead, so you sent a check to Excellus on July 1, 2016 for your June and July premium payments.

6) You testified that you had surgery on [redacted] believing that your coverage was active.

7) You testified that, when you came home from the hospital, you saw that NYSOH sent you a notice stating that your coverage was terminated as of June 30, 2016.

8) Your NYSOH account reflects that NYSOH issued this disenrollment notice on July 2, 2016.

9) You testified that you then received a letter from Excellus on July 15, 2016 stating that your coverage had been terminated on June 30, 2016.

10) You testified that Excellus sent you this letter after cashing the check you sent on July 1, 2016 to pay for your June and July premiums.

11) You testified that you also attempted to make a premium payment for August 2016 in a check that you mailed on August 27, 2016. You testified that this check cleared your bank account on September 13, 2016.

12) You testified that you had no insurance coverage from the end of June 2016 through November 1, 2016.

13) You testified that you tried to reapply for coverage several times in July 2016, but that there was a technical problem that prevented your

application from going through, and the NYSOH representatives that you spoke with informed you that the issue had been sent to technical support.

14) Your NYSOH account reflects that you attempted to apply for financial assistance on July 8, 10, and 13, 2016, but no eligibility determinations were issued by NYSOH with regard to these applications.

15) Incident # [redacted] in NYSOH's system indicates that NYSOH acknowledged that there was a defect (# [redacted], filed on July 29, 2016) that caused your July 2016 applications not to be processed.

16) A note entered on October 4, 2016 in Incident # [redacted] states "The consumer, [redacted], would be due a backdate in EP for the period 8/1/16-10/31/16 along with being responsible for the monthly premiums."

17) A noted entered on October 11, 2016 in the same Incident states "Sending incident to correct coverage in EP for the period 8/1/16 - 10/31/16."

18) Your NYSOH account does not contain any notices informing you of this Essential Plan eligibility for the period of August 1, 2016 through October 31, 2016, nor are there any enrollments for that time period.

19) You testified that you had a household of three in July, 2016, consisting of yourself, your son, and his girlfriend. You testified that you claim both of them as dependents, and that neither of them had any income in July 2016.

20) You testified that you are now enrolled in coverage through your employer, outside of NYSOH.

21) You testified that you are looking for any coverage you are eligible for in the month of July 2016 for yourself because you have outstanding medical bills from the surgery that you had that month.

22) After the hearing, you uploaded eight documents to your NYSOH account as follows:

a. A one-page Excellus invoice showing a due date of 5/1/16, and a payment of $40.00 made on 4/11/16, with a handwritten note stating "4/1/16 and 5/1/16 premiums;"
b. A one-page Excellus billing summary showing a date billed of 6/30/16 and a due date of 6/1/16 for an amount due of $20.00 for the period of 6/1/16 - 6/30/16 with a handwritten note stating "Pd 6/1/16 + 7/1/16 premiums 7/1/16 ck [redacted];"
c. A one-page Excellus billing summary showing a date billed of 6/8/16 and a due date of 7/1/16 for an amount of $40.00, with an

outstanding balance of $20.00 included in that total, and a handwritten note stating "Pd ck# [redacted] 7/1/16;"

d. A one-page letter from Excellus dated July 15, 2016 stating that your health insurance policy has ended, and that it is your responsibility to pay for any services you receive after 6/30/16;
e. Copies of five paystubs in your name for the following dates and gross earnings:
    i. 7/1/16 - $592.00 w/$23.68 401K deduction;
    ii. 7/8/16 - $706.00 w/$28.24 401K deduction;
    iii. 7/15/16 -$560.00 w/$22.40 401K deduction;
    iv. 7/22/16 - $652.00 w/$26.08 401K deduction;
    v. 7/29/16 - $742.00 w/$29.68 $401K deduction;
f. A copy of a check drawn on an account n your name, [redacted], made out to "Excellus Health Plan" in the amount of $20.00, with the back of the check showing information regarding the check clearing, including a date of 9/13/16;
g. A copy of a check drawn on an account in your name, [redacted], made out to "Excellus Health Plan" in the amount of $40.00, with the back of the check showing information regarding the check clearing, including a date of 7/11/16;
h. A second copy of the letter from Excellus, as stated in "d" above

(Documents [redacted], and [redacted]).

Taken together, these documents are collectively marked and entered into the record as "Appellant's Exhibit One."

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Appealable Issues

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, (3) an eligibility determination for an exemption, (4) a failure by the Exchange to provide timely notice of an eligibility determination (155.405), and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Redetermination During a Benefit Year

When a redetermination is issued as a result of a change in an applicant's information, NYSOH must generally make that redetermination effective on the first day of the month following the date NYSOH is notified of the change (45 CFR § 155.330 (f)(1)(ii)). However, NYSOH may determine that its policy will be that any change made after the 15th of any month will not be effective until the first of the second following month (45 CFR § 155.330(f)(2)).

When an eligibility redetermination results in a change in the amount of advance payments of the premium tax credit (APTC) for the benefit year, NYSOH must recalculate the amount of APTC in such a manner as to account for any advance payments already made on behalf of the tax filer, such that the recalculated advance payment amount is projected to result in total advance payments for the benefit year that correspond to the tax filer's total projected premium tax credit for that benefit year (45 CFR § 155.330(g)).

Enrollment in a Qualified Health Plan

The effective date of coverage by a qualified health plan is determined by the date on which an applicant selects a plan for enrollment. For individuals who are eligible for enrollment, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i)). For selections received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(ii)).

Medicaid for Adults between the Ages of 19 and 65

Medicaid through NYSOH can be provided to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 435.603(d)(4); NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of your application, that was the 2016 FPL, which is $20,160.00 for a three-person household (81 Federal Register 4036).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size

(42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of application if the individual received medical services that would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time he received the services if he had applied (42 CFR § 435.915(a)). The Department of Health may make eligibility effective for fee-for-service Medicaid on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Legal Analysis

The New York State of Health Appeals Unit only has the authority to review issues related to the following: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, (3) an eligibility determination for an exemption, (4) a failure by the Exchange to provide timely notice of an eligibility determination and (5) a denial of a for a special enrollment period.

Since the Appeals Unit is not given the authority to review termination of enrollment due to non-payment of premiums, we cannot reach the merits as to whether you were properly terminated from your health plan for nonpayment of premiums. Likewise, we therefore lack the authority to make a determination that you should be placed back into the plan from which you were terminated for nonpayment of premiums.

However, it is clear from the record that you made premium payments to Excellus by checks that were cashed, including one that was cashed after Excellus sent a letter stating that your policy had ended. Therefore, we are RETURNING your case to NYSOH's Plan Management Unit to further investigate this issue and to notify you of the outcome of this investigation.

The first issue under review is whether NYSOH properly determine that your eligibility for enrollment in a qualified health plan with APTC was effective no earlier than November 1, 2016.

The record shows that on September 29, 2016, you updated the information in your NYSOH account. On October 8, 2016, NYSOH issued a notice of eligibility determination, based on the information in your September 29, 2016 application, stating that you were eligible to enroll in a qualified health plan and receive up to $278.00 per month in APTC (to be shared with your son), effective November 1, 2016.

When an individual changes information in their application after the 15th of any month, NYSOH will make the redetermination that results from the change effective the first day of the second following month.

Therefore, NYSOH's October 8, 2016 eligibility determination notice is AFFIRMED because it properly began your eligibility for enrollment in a qualified health plan with APTC on November 1, 2016.

However, on October 7, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective November 1, 2016. This eligibility determination appears to be based on a July 13, 2016 application that was never processed. Notes in NYSOH's system indicate that a defect prevented your July 2016 applications from being timely processed.

Had your July 13, 2016 application gone through, this eligibility determination would have been issued in July 2016, and you would have been eligible for the Essential Plan as of August 1, 2016. Indeed, notes in NYSOH's system also indicate that NYSOH determined that you should have retroactive Essential Plan coverage for the period of August 1, 2016 through October 31, 2016, at which point you became eligible for APTC, based on updated information in your NYSOH account.

Therefore, the October 7, 2016 eligibility determination is MODIFIED to state that you were eligible to enroll in an Essential Plan with a $20.00 monthly premium, effective August 1, 2016.

Your case is RETURNED to NYSOH to facilitate your enrollment in an Essential Plan for the period of August 1, 2016 through October 31, 2016, should you choose to enroll in a plan for that period. You will be responsible for any premium payments.

The second issue under review is whether NYSOH properly determined that you were not eligible for Medicaid in the month of July 2016.

As of July 2016, you were in a three-person household, and you planned to file your tax return as head of household and claim two dependents.

The record reflects that you submitted your initial application on July 13, 2016. When an individual files an initial application for Medicaid, his or her eligibility for retroactive Medicaid depends on the date of application. To this end, it does not matter whether or not that initial application resulted in Medicaid going forward. Instead, an individual, who has filed an initial application for Medicaid through NYSOH, has the right to be evaluated for Medicaid for the three months before the month of his or her application.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's initial application if the individual received medical services that would have been covered under Medicaid and if they would have been eligible for Medicaid in those three months had they applied.

You testified that you are seeking to have any coverage you may be eligible for in the month of July 2016.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. To be eligible for Medicaid in July 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $2,318.40 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during July 2016.

You testified that you are paid weekly. You uploaded paystubs showing that you earned a gross income of $3,121.92, after your 401K deductions. Therefore, the record indicates that in the month of July 2016, you had a monthly household income of $3,121.92.

Since your income of $3,121.92 was more than the $2,318.40 monthly Medicaid limit for July 2016, NYSOH properly determined that you were not eligible for Medicaid coverage during that month. Therefore, the September 30, 2016 eligibility determination, insofar as it stated that you were not eligible for Medicaid in the month of July 2016, is correct and is AFFIRMED.

Decision

The September 30, 2016 eligibility determination notice is AFFIRMED.

The October 8, 2016 eligibility determination notice is AFFIRMED.

The October 7, 2016 eligibility determined is MODIFIED to state that you were eligible for enrollment in the Essential Plan with a $20.00 monthly premium for the period of August 1, 2016 through October 31, 2016.

Your case is being referred to Plan Management to investigate the propriety of the termination of your coverage with your Essential Plan coverage, and your assertion that the termination had occurred after premium payments were made.

Your case is RETURNED to NYSOH to assist you in enrolling in an Essential Plan for the months of August, September, and October 2016, should you choose to enroll in a plan for that time period.

Effective Date of this Decision: March 24, 2017

How this Decision Affects Your Eligibility

You were eligible for APTC and enrollment in a qualified health plan as of November 1, 2016.

You were eligible to enroll in Essential Plan coverage for the period of August 1, 2016 through October 31, 2016.

Your case is being sent back to NYSOH to assist you in enrolling in an Essential Plan for August 1, 2016 through October 31, 2016, should you choose to do so.

Your case is being referred to Plan Management to investigate the propriety of the termination of your coverage with your Essential Plan coverage, and your assertion that the termination had occurred after premium payments were made.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to the Federal Marketplace or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months of the Decision Date, which appears on the first page of this Decision.

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the Federal Marketplace. This must be done within 30 days of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:

  Health Insurance Marketplace
  Attn: Appeals
  465 Industrial Blvd.
  London, KY 40750-0061

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

- By fax: 1-877-369-0129

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

If You Have Questions about this Decision (Customer Service Resources):

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The September 30, 2016 eligibility determination notice is AFFIRMED.

The October 8, 2016 eligibility determination notice is AFFIRMED.

The October 7, 2016 eligibility determined is MODIFIED to state that you were eligible for enrollment in the Essential Plan with a $20.00 monthly premium for the period of August 1, 2016 through October 31, 2016.

Your case is being referred to Plan Management to investigate the propriety of the termination of your coverage with your Essential Plan coverage, and your assertion that the termination had occurred after premium payments were made.

Your case is RETURNED to NYSOH to assist you in enrolling in an Essential Plan for the months of August, September, and October 2016, should you choose to enroll in a plan for that time period.

You were eligible for APTC and enrollment in a qualified health plan as of November 1, 2016.

You were eligible to enroll in Essential Plan coverage for the period of August 1, 2016 through October 31, 2016.

Your case is being sent back to NYSOH to assist you in enrolling in an Essential Plan for August 1, 2016 through October 31, 2016, should you choose to do so.

Your case is being sent back to Plan Management to investigate the termination of your Essential Plan coverage as of June 30, 2016 for nonpayment of premiums, based on the documentation you submitted after the hearing.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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।

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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)

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