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

Notice of Decision

Decision Date: May 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013930

Dear [redacted],

On May 10, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 11, 2016 preliminary determination, October 12, 2016 disenrollment notice, and December 10, 2016 plan enrollment confirmation notice.

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: May 30, 2017

NY State of Health Account ID
Appeal Identification Number: AP000000013930

Issues

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

> Did NY State of Health provide a timely determination of your Medicaid eligibility, effective July 1, 2016?
>
> Did NY State of Health properly determine that you were ineligible for fee-for-service Medicaid, effective October 31, 2016?
>
> Did NY State of Health properly determine that your Medicaid Managed Care plan began January 1, 2017?

Procedural History

On July 1, 2016, you submitted a paper application for Medicaid to your local Department of Social Services office.

On August 3, 2016, NY State of Health (NYSOH) received your paper application from your local Department of Social Services.

On August 12, 2016, NYSOH issued a notice stating that NYSOH had received your application dated July 1, 2016 but that more information was needed such as your date of birth, where you live, and how the people in your household were related to each other. This notice further directed you to update your NYSOH account in order for your application to be processed.

On September 29, 2016, NYSOH received your updated application for health insurance.

On October 8, 2016, NYSOH issued an eligibility determination, based on your September 29, 2016 application, stating that you were eligible for up to $220.00 per month in advanced premium tax credits (APTC) and cost-sharing reductions if you enrolled into a silver level qualified health plan for a limited time, effective November 1, 2016. This notice also stated that you may be able to enroll in coverage if you qualified for a special enrollment period. The notice further directed you to submit income documentation by December 27, 2016.

On October 11, 2016, NYSOH received your updated application for health insurance. A preliminary determination was prepared that day stating that you were eligible for fee-for-service Medicaid, effective October 1, 2016.

Also on October 11, 2016, NYSOH received a second application for health insurance.

On October 12, 2016, NYSOH issued a plan enrollment notice confirming your enrollment in fee-for-service Medicaid, effective October 1, 2016.

Also on October 12, 2016, NYSOH issued an eligibility determination, based on the second application filed on October 11, 2016, stating that you were eligible for $220.00 per month in APTC and cost-sharing reductions if you enrolled into silver level qualified health plan, effective November 1, 2016 for a limited time. This notice also stated that you were not eligible for a special enrollment period.

Finally, on October 12, 2016, NYSOH issued a plan disenrollment notice confirming your disenrollment from fee-for-service Medicaid, effective October 31, 2016.

On November 30, 2016, NYSOH received your updated application for health insurance.

On December 1, 2016, NYSOH issued a notice stating that the income information that you entered into your November 30, 2016 application did not match state and federal data sources. This notice further directed you to submit income documentation by December 15, 2016.

On December 8, 2016, NYSOH validated and verified your income documentation and a new application was submitted on your behalf.

On December 9, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective December 1, 2016. This notice also directed you to pick a plan for enrollment.

On December 9, 2016, you selected a Medicaid Managed Care (MMC) plan for enrollment.

Also on December 9, 2016, you spoke to NYSOH's Account Review Unit and appealed insofar as your enrollment in your MMC plan began on January 1, 2017 and not August 1, 2016.

On December 10, 2016, NYSOH issued a plan enrollment notice confirming your enrollment in your Medicaid Managed Care plan, based on your December 9, 2016 selection, effective January 1, 2017.

On May 10, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and the record was held open until May 25, 2017 to allow you time to submit supporting income documentation.

On May 23, 2017, NYSOH Appeals Unit received a fax with the requested income documentation and the record was closed upon receipt. Your fax was marked as Appellant's Exhibit #1 and it was incorporated into the record.

Findings of Fact

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

1) You testified, and the record reflects, that you were pregnant with one child in July 2016 and subsequently lost that pregnancy in July 2016.

2) You submitted an application for insurance to your Local Department of Social Services on July 1, 2016. That application listed your date of birth, where you live, and that you were the only person in your household.

3) You testified that you called NYSOH multiple times to inquire about your paper application in August 2016 and September 2016 but were told multiple different things depending on what representative you had on the phone.

4) Your July 1, 2016 application states that you were receiving $371.88 a week in unemployment insurance benefit payments and that this was the only income that you were receiving at that time.

5) You submitted your unemployment insurance benefit payment history that shows that you received $425.00, before taxes, on July 5, 2016, July 11, 2016, July 18, 2016, and July 25, 2016.

6) The record reflects that you were first found eligible for Medicaid in July 2016.

7) The record reflects that two applications were submitted on October 11, 2016. The first application that was submitted on October 11, 2016 listed an expected annual income of $11,050.00, and a monthly income of $1,700.00 and the second application that was submitted on October 11, 2016 listed an expected annual income of $25,496.00.

8) The record reflects that in the month of October 2016 you received an unemployment insurance benefit payment of $425.00, before taxes, on October 3, 2016, and an unemployment insurance benefit payment of $430.00, before taxes, on October 11, 2016 and October 17, 2016.

9) The record reflects that you did not select a MMC plan for enrollment until December 9, 2016.

10) You testified that you are seeking you MMC plan start date to be backdated to August 1, 2016 because you have unpaid medical bills.

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

Applicable Law and Regulations

Medicaid

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

Medicaid Managed Care plan enrollments received on or before the fifteenth day of the month are effective the first day of the following month. Enrollments received after the fifteenth day of the month are effective the first day of the second following month (Medicaid Managed Care Model Contract (Appendix H-6(b)(ii) & (iii), effective 3/1/2014 – 2/28/2019; *see* 42 USC § 1315; § 364-j(1)(c); 18 NYCRR § 360-10.3(h), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

Medicaid-Pregnant Women

For purposes of Medicaid eligibility, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver (42

CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size (see 42 CFR § 435.116(c); New York State Department of Health 13 OHIP/ADM-03). Once eligible, a pregnant woman will remain eligible until the end of the month in which the sixtieth day following the end of the pregnancy occurs, regardless of any change in household income, even if such change would render her ineligible for financial assistance (NY Social Services Law § 366(4)(b)(1)).

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).

Medicaid-Adult

Medicaid can be provided through NYSOH 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 FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

Timely Notice of Medicaid Eligibility

When an individual applies for insurance through NYSOH, NYSOH must determine that person's eligibility promptly and without undue delay (45 CFR § 155.310(e)(1); 42 CFR § 435.1200(b)(3)(iii)).

To assess whether an eligibility determination was untimely, NYSOH must base the time period from the date of application to the date NYSOH notifies the applicant of its decision (45 CFR § 155.310(e)(2)). However, if the applicant submits an incomplete application or there is not sufficient information for NYSOH to make an eligibility determination, then NYSOH must notify that applicant that more information is needed to complete the application (45 CFR § 155.310(k)(1)).

NYSOH must provide pregnant Medicaid applicants notice of their eligibility determination within 30 days from the date of the completed application (18 NYCRR § 360.2.4(3)(i)).

Medicaid Continuous Coverage

Most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, unless the adult loses Medicaid eligibility because of citizenship status, lack of state residence, or failure to provide a valid social security number, before the end of a twelve-month period. This twelve-month period is referred to as “continuous coverage,” and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (*see* 42 CFR § 435.916(a); N.Y. Soc. Serv. Law § 366(4)(c)).

Legal Analysis

The first issue is whether NYSOH provided you with a timely determination of your Medicaid eligibility, effective July 1, 2016.

You submitted a paper application for health insurance through your local department of social services office on July 1, 2016.

On August 12, 2016, NYSOH issued a notice stating that they had received the application dated July 1, 2016, but were unable to make an eligibility determination because they needed more information about your household member demographics. The notice further directed you to contact NYSOH to complete your application.

However, the July 1, 2016 application contained your date of birth, where you live, and that you were the only person in your household, which is what NYSOH stated that you were missing to complete your application. Therefore, all the necessary information was available to NYSOH at the time the July 1, 2016 application was completed. Therefore, your application was considered complete as of July 1, 2016 for purposes of issuing an eligibility determination.

NYSOH must provide Medicaid applicants who are pregnant notice of their eligibility determination within 30 days from the date of the completed application. To assess whether an eligibility determination was untimely, NYSOH must base the time period from the date of the completed application to the date NYSOH notifies the applicant of its decision.

Since NYSOH never issued an eligibility determination based on your July 1, 2016 completed application, NYSOH failed to timely provide you with an eligibility determination.

Medicaid can be provided through NYSOH to pregnant women who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 223% of the FPL for the applicable family size. For purposes of Medicaid eligibility, the household size of a pregnant woman

includes not only the pregnant woman, but also the number of children she expects to deliver.

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

On your July 1, 2016 application, you indicated that you were pregnant. The application also stated that you were receiving $371.88 a week from your unemployment insurance benefits and that this was your only income. However, on May 23, 2017, you submitted your unemployment insurance benefit payment history that shows in July 2016 you received $425.00 a week, before taxes, in unemployment insurance benefits.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 223% of the FPL, which is $2,978.00 per month for a two-person household. Since the documentation you provided shows that you earned $1,700.00 in July 2016 you would have qualified for Medicaid based on monthly income as of the date of your July 1, 2016 application.

Therefore, had NYSOH issued a timely determination notice stating that you were eligible for Medicaid, effective July 1, 2016, you would have been able to select an MMC plan for enrollment that day.

The date on which enrollment in a MMC plan can take effect depends on the day a person selects a plan for enrollment.

A plan that is selected from the first day to and including the fifteenth day of a month goes into effect on the first day of the following month. A plan that is selected from the sixteenth day of the month to the end of the month goes into effect on the first day of the second following month.

Based on the credible evidence of record, it is reasonable to infer that had you received an eligibility determination notice informing you of your eligibility for Medicaid, effective July 1, 2016 and directing you to select a MMC plan for enrollment, you would have selected a MMC plan for enrollment that day. Had you known to select a MMC plan on July 1, 2016 and been able to do so, your MMC plan would have taken effect on the first day following July 2016; that is, August 1, 2016.

Once eligible, a pregnant woman will remain eligible until the end of the month in which the sixtieth day following the end of the pregnancy occurs, regardless of any change in household income, even if such change would render her ineligible for financial assistance.

You testified, and the record indicates, that you lost your pregnancy in early July 2016. Therefore, your enrollment in your MMC plan should have continued until

the end of the month in which the sixtieth day following the end of the pregnancy occurs, or until September 30, 2016.

Therefore, your case is RETURNED to NYSOH to assist you in enrolling into a MMC plan of your choice for the months of August 2016 and September 2016.

The second issue is whether NYSOH properly determined that you were ineligible for fee-for-service Medicaid, effective October 31, 2016.

On October 11, 2016, NYSOH received your updated application for health insurance which stated that your expected annual household income was $11,050.00. That day, a preliminary eligibility determination was prepared stating that you were eligible for Medicaid, effective October 1, 2016. Subsequently, NYSOH issued a plan enrollment notice confirming that you were enrolled in fee-for-service Medicaid, effective October 1, 2016.

Generally, once individuals are determined eligible for Medicaid, they are guaranteed 12 months of Medicaid coverage, even if the adult loses Medicaid eligibility because of any changes or updates they made to their NYSOH account. This twelve-month period is based on the effective date of the Medicaid eligibility determination.

The record reflects that a second application was submitted to NYSOH on October 11, 2016, and your household income was changed from $11,050.00 to $25,496.00 with a monthly income of $1,700.00. Subsequently, NYSOH found you ineligible for Medicaid effective October 31, 2016.

Once a person is eligible for Medicaid, the eligibility continues for 12 months even if the household income rises above 138% of the FPL. When your Medicaid coverage terminated on October 31, 2016, the twelve-month period of Medicaid eligibility that was effective on October 1, 2016, had not expired.

Therefore, the October 12, 2016 disenrollment notice is RESCINDED.

The third issue is whether NYSOH properly determined the start date of your MMC plan with Excellus Health began on January 1, 2017.

The date on which enrollment in a MMC plan can take effect depends on the day a person selects a plan for enrollment.

A plan that is selected from the first day to and including the fifteenth day of a month goes into effect on the first day of the following month. A plan that is selected from the sixteenth day of the month to the end of the month goes into effect on the first day of the second following month.

You were found eligible for fee-for-service Medicaid on October 11, 2016. You were unable to pick a MMC plan for enrollment that day because the eligibility determination notice stated that the Medicaid you were eligible for did not allow you to enroll in a plan. However, you should have been able to select a MMC plan for enrollment that day because NYSOH properly found you to be eligible for Medicaid as of October 1, 2016 based on the first application your submitted on October 11, 2016.

Based on the credible evidence of record, it is reasonable to infer that had you been able to select a plan for enrollment on October 11, 2016, you would have selected a MMC plan for enrollment that day. Had you known to select a MMC plan on October 11, 2016 and been able to do so, your MMC plan would have taken effect on the first day following October 2016; that is, November 1, 2016.

Therefore, the December 10, 2016 plan enrollment notice is MODIFIED to state that your MMC plan with Excellus Health coverage begins on November 1, 2016, and not January 1, 2017.

Decision

Your case is RETURNED to NYSOH to contact you and to assist you in enrolling into a Medicaid Managed Care plan of your choice for the months of August 2016 and September 2016.

The October 11, 2016 preliminary eligibility determination stating that you were eligible for Medicaid is AFFIRMED.

The October 12, 2016 disenrollment notice is RESCINDED.

The December 10, 2016 plan enrollment notice is MODIFIED to state that your enrollment in your Medicaid Managed Care plan with Excellus Health began on November 1, 2016, and not on January 1, 2017.

Your case is RETURNED to NYSOH to ensure that your coverage in your Excellus Medicaid Managed Care plan is effective as of November 1, 2016.

Effective Date of this Decision: May 30, 2017

How this Decision Affects Your Eligibility

You were eligible for Fee-For-Service Medicaid for the months of July 2016 and October 2016.

Your enrollment in a Medicaid Managed Care plan began on August 1, 2016 and ended on September 20, 2016.

Your enrollment in your Medicaid Managed Care plan with Excellus Health is effective November 1, 2016.

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

- 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):

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).

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

Your case is RETURNED to NYSOH will contact you and assist you in enrolling into a Medicaid Managed Care plan of your choice for the months of August 2016 and September 2016

The October 12, 2016 disenrollment notice is RESCINDED.

The December 10, 2016 plan enrollment notice is MODIFIED to state that your enrollment in your Medicaid Managed Care plan with Excellus Health began on November 1, 2016, and not on January 1, 2017.

You were eligible for Fee-For-Service Medicaid for the months of July 2016 and October 2016.

Your enrollment in a Medicaid Managed Care plan began on August 1, 2016 and ended on September 20, 2016.

Your enrollment in your Medicaid Managed Care plan with Excellus Health is effective November 1, 2016.

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)

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).

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 निःशुल्क 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.

(Urdu)اردو

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)

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).

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.

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).