



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

Notice of Decision

Decision Date: May 05, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000014623

[REDACTED]

Dear [REDACTED],

On March 30, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health’s September 10, 2016 disenrollment notice, October 5, 2016 enrollment notice, and November 3, 2016 eligibility determination.

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 NY State of Health 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: May 05, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000014623

[REDACTED]

Issues

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

Was your appeal of NY State of Health's (NYSOH) September 10, 2016 disenrollment notice, October 5, 2016 enrollment notice, and November 3, 2016 eligibility determination timely?

Did NYSOH properly determine that your youngest child's enrollment in her Medicaid Managed Care (MMC) plan should be terminated effective September 30, 2016?

Did NYSOH properly determine that your youngest child's eligibility for and enrollment in her Child Health Plus (CHP) plan was effective November 1, 2016?

Did NYSOH properly determine that your youngest child was not eligible for retroactive Medicaid for October 1, 2016 through October 31, 2016?

Procedural History

On October 31, 2015, NYSOH issued a notice of eligibility determination stating that your youngest child was eligible for Medicaid because your household income was at or below the allowable income limit. This eligibility was effective as of September 1, 2015.

Also on October 31, 2015, NYSOH issued an enrollment notice confirming your youngest child's enrollment in an MMC plan as of December 1, 2015.

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On August 3, 2016, NYSOH issued a renewal notice, stating that there was not enough information to determine whether your youngest child was eligible to continue her financial assistance for health insurance, and that you needed to update your NYSOH account by September 15, 2016 or the financial assistance she was receiving might end.

On September 9, 2016, NYSOH received your updated application for health insurance; specifically, the income information was updated.

On September 10, 2016, NYSOH issued a notice stating more information was needed to make a determination. The notice explained the income documentation you provided NYSOH did not match what was obtained from state and federal data sources. You were asked to submit income documentation for your household by September 24, 2016.

Also on September 10, 2016, NYSOH issued a disenrollment notice stating that your youngest child's MMC plan coverage would end effective September 30, 2016.

On September 12, 2016, you uploaded paystubs to your online account.

On September 20, 2016, NYSOH verified the uploaded paystubs.

Also on September 20, 2016, NYSOH ran an application on your behalf for financial assistance with health insurance.

On September 21, 2016 NYSOH issued a notice of eligibility determination, based on the September 20, 2016 application, stating that your youngest child was eligible to enroll in CHP with a \$9.00 monthly premium, effective November 1, 2016

On October 5, 2016, NYSOH issued a notice of enrollment stating that your youngest child was enrolled in a CHP plan, and that her enrollment in the plan would start November 1, 2016.

On November 2, 2016, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for your youngest child for October 2016.

On November 3, 2016, NYSOH issued an eligibility determination notice stating that your youngest child was not eligible for Medicaid for October 1, 2016 through October 31, 2016 because the program she was eligible for cannot pay for any care you received in the past.

On January 5, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determinations for your youngest child, insofar as she did not have coverage in October 2016.

On March 30, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing held open up to April 14, 2017, to allow you to submit supporting documents and to allow the Hearing Officer time to review telephone calls you made to the Marketplace between September and December 2016. Four telephone calls were reviewed.

On April 13, 2017, NYSOH received the requested documentation and it was incorporated into the record as Appellant's Exhibit #1. The record was closed that day.

Findings of Fact

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

- 1) You testified that you are seeking coverage for your youngest child for October 2016.
- 2) You testified that you were advised by a NYSOH representative that your youngest child had coverage in October 2016.
- 3) Applications for financial assistance were submitted on September 9, 2016 and November 2, 2016.
- 4) You placed a call to NYSOH on September 9, 2016. During that call you renewed the application for your household and were advised that you needed to provide proof of income. The NYSOH representative advised you that your youngest child's coverage would be effective until the end of the month.
- 5) On September 9, 2016, you faxed two paystubs to NYSOH. They were uploaded to your account on September 12, 2016. The paystubs were dated August 19, 2016 with a gross pay amount of \$1,219.80 and September 2, 2016 with a gross pay amount of \$1,331.45.
- 6) You placed a call to NYSOH on September 16, 2016. During that call, the NYSOH representative confirmed that your income documentation had been received but that it had not yet been verified. You were advised to call back the following Monday.
- 7) On September 20, 2016, NYSOH verified the paystubs you faxed on September 9, 2016.

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- 8) You placed a call to NYSOH on October 4, 2016. During that call, you indicated that you were seeking clarification regarding your youngest child's coverage. You were at the doctor and had been advised that your youngest child had no coverage. The call ended abruptly.
- 9) You placed a call to NYSOH on November 22, 2016. During that call, the NYSOH representative said that she did not see anything in your account to indicate that your youngest child did not have coverage in October 2016. The representative also advised you that your youngest child had Medicaid coverage in October 2016, and suggested that you send any outstanding bills to Medicaid. Furthermore, you were advised that your youngest child was eligible for and enrolled in a Child Health Plus plan effective November 1, 2016.
- 10) Your application submitted on November 2, 2016, states that your annual expected income is \$33,166.25. You testified that amount was correct.
- 11) You testified that you are paid bi-weekly.
- 12) You faxed a paystub dated October 14, 2016 for a gross pay amount of \$1,407.70 and a paystub dated October 28, 2016 for a gross pay amount of \$2,065.46.
- 13) The record reflects that your youngest child was enrolled in a CHP plan on October 4, 2016, with a plan start date of November 1, 2016.
- 14) You testified that you need your youngest child to have coverage for October 2016 because she has an outstanding bill for services rendered that month.

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

Applicable Law and Regulations

Valid Appeal Requests

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 45

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CFR § 155.505; 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)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR §155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

Medicaid for Children

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the federal poverty level (FPL) for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

In the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all persons whom such individual expects to claim as a tax dependent (42 CFR § 435.603(f)(1)).

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 Fed. Reg. 4036).

Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every 12 months or “whenever it receives information about a change in a beneficiary’s circumstances that may affect eligibility” (42 CFR § 435.916(a)(1), (d)). NYSOH must make its “redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency” (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates provided by the individual (45 CFR §155.335(h)).

Under New York’s Social Services Law, a person who is found eligible for Medicaid based on her household’s modified adjusted gross income (MAGI) but

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loses that eligibility “for a reason other than citizenship status, lack of state residence, or failure to provide a valid social security number” keeps their Medicaid coverage for twelve months, “provided that federal financial participation in the costs of such assistance is available” (N.Y. Soc. Serv. Law § 366(4)(c)). This provision is referred to as “continuous coverage” and the twelve-month period of continuous coverage is based on the date of Medicaid eligibility.

Retroactive Medicaid

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of an initial 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 USCA § 1396A(34); 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)).

Child Health Plus

The “period of eligibility” for Child Health Plus is “that period commencing on the first day of the month during which a child is an eligible child and enrolled or recertified for enrollment on an annual basis based on all required information and documentation and ending on the last day of the twelfth month following such date,” unless the CHP premiums are not timely paid or the child no longer resides in New York State, gains access to or obtains other health insurance coverage, or becomes eligible for Medicaid (NY Public Health Law § 2510(6)).

“A State must specify a method for determining the effective date of eligibility for [Child Health Plus], which can be determined based on the date of application or through any other reasonable method that ensures coordinated transition of children between [Child Health Plus] and other insurance affordability programs as family circumstances change and avoids gaps or overlaps in coverage” (42 CFR § 457.340(f)).

The State of New York has provided that a child’s period of eligibility for Child Health Plus begins on the first day of the month during which a child is eligible. A child will become eligible on the first day of the next month, if the application is received by the 15th of the month; applications received after the 15th day of the month will be processed for the first day of the second following month (see e.g. State Plan Amendment (SPA) NY-14-0005, approved February 3, 2015 and effective January 1, 2014).

Legal Analysis

The first issue under review is whether your appeal of NYSOH's September 10, 2016 disenrollment notice, October 5, 2016 enrollment notice, and November 3, 2016 eligibility determination was timely.

The record reflects that you first contacted NYSOH on October 4, 2016 for clarification regarding your youngest child's coverage in October 2016. On January 5, 2017, you filed a formal appeal with NYSOH regarding her lack of coverage in October 2016.

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH. For an appeal to have been valid on the issue of your youngest child's disenrollment from her MMC plan as stated in the September 10, 2016 disenrollment notice, an appeal should have been filed by November 10, 2016. For an appeal to have been valid on the issue of your youngest child's CHP start date as stated in the October 5, 2016 enrollment confirmation notice, an appeal should have been filed by December 5, 2016. For an appeal to have been valid on the denial of retroactive Medicaid coverage for your youngest child in October of 2016 as stated in the November 3, 2016 eligibility determination notice, an appeal should have been filed by January 3, 2017.

However, you originally contacted NYSOH on October 4, 2016, within sixty days of the September 10, 2016 disenrollment notice to question her coverage. You again contacted NYSOH on November 22, 2016. You were not notified at any point that your child had been disenrolled for the month of October 2016. In fact, on November 22, 2016, you were erroneously informed that your youngest child had Medicaid coverage in October 2016. Therefore, your failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal.

The second issue under review is whether NYSOH properly determined that your youngest child's enrollment in her MMC plan was properly terminated effective September 30, 2016.

Generally, NYSOH must redetermine a qualified individual's eligibility for Medicaid once every twelve months without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency. NYSOH's August 3, 2016 renewal notice stated that there was not enough information to determine whether your youngest child was eligible to continue her financial assistance for health insurance, and that you needed to update your account by September 15, 2016 or her financial assistance might end.

Your youngest child was originally found eligible for Medicaid effective September 1, 2015 and enrolled in an MMC plan effective December 1, 2015. Twelve months from September 1, 2015 would be September 30, 2016. Note that the twelve month period begins as of the date the person was found eligible for regular Medicaid coverage, not from the date the person was enrolled in a Medicaid Managed Care plan.

The record shows although there was a timely response to the August 3, 2016 renewal notice, your youngest child's eligibility could not be determined because you needed to provide documentation regarding household income. She was subsequently disenrolled from her MMC plan effective September 30, 2016, twelve months after her original eligibility.

Therefore, the September 10, 2016 notice of disenrollment is AFFIRMED because NYSOH properly ended your youngest child's eligibility for and enrollment in her MMC plan on September 30, 2016, twelve months from her original eligibility determination.

The third issue is whether NYSOH properly determined that your youngest child's enrollment in her CHP plan was effective November 1, 2016.

The record reflects that your youngest child was enrolled into a CHP plan on October 4, 2016.

The date on which a CHP plan can take effect depends on the day a person selects the plan for enrollment. A plan that is selected between the first day and 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 and the end of the month goes into effect on the first day of the second following month.

Therefore, the October 5, 2016 enrollment confirmation notice stating that your child's enrollment in her CHP plan was effective November 1, 2016, is correct and must be AFFIRMED.

The fourth issue under review is whether NYSOH properly determined that your youngest child was not eligible for retroactive Medicaid for October 1, 2016 through October 31, 2016.

Your youngest child is in a three-person household.

You submitted an application for financial assistance on November 2, 2016 and requested help in paying for medical bills for your youngest child for October 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

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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.

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 October 2016, your child would have needed to meet the non-financial criteria and have an income no greater than 154% of the FPL, which is \$2,588.00 per month. There is no indication in the record that your youngest child would have been ineligible for Medicaid based on non-financial criteria during October 2016.

You testified that you are paid bi-weekly. You faxed a paystub dated October 14, 2016 for a gross pay amount of \$1,407.70 and a paystub dated October 28, 2016 for a gross pay amount of \$2,065.46. Therefore, the record indicates that in the month of October 2016, you had a monthly household income of \$3,473.16.

Since your income of \$3,473.16 was more than the \$2,065.46 monthly Medicaid limit for October 2016, NYSOH properly determined that your youngest child was not eligible for Medicaid coverage during that month. Therefore, the November 3, 2016 eligibility determination stating that your youngest child was not eligible for Medicaid in the month of October 2016, is correct and however it is MODIFIED to state that your youngest child is not eligible for retroactive Medicaid because your household's monthly income exceeded the limit for Medicaid in October 2016.

Decision

The September 10, 2016 disenrollment notice is AFFIRMED.

The October 5, 2016 enrollment notice AFFIRMED.

The November 3, 2016 eligibility determination is MODIFIED to state that your youngest child is not eligible for retroactive Medicaid because your household's monthly income exceeded the limit for Medicaid in October 2016.

Effective Date of this Decision: May 05, 2017

How this Decision Affects Your Eligibility

This decision does not change your child's eligibility.

Your youngest child's enrollment in her MMC plan properly ended as of September 30, 2016.

The effective date of your youngest child's CHP plan is November 1, 2016.

Your youngest child is not eligible for retroactive Medicaid for October 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

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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
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- By fax: 1-855-900-5557

Summary

The September 10, 2016 disenrollment notice is AFFIRMED.

The October 5, 2016 enrollment notice AFFIRMED.

The November 3, 2016 eligibility determination is MODIFIED to state that your youngest child is not eligible for retroactive Medicaid because your household's monthly income exceeded the limit for Medicaid in October 2016.

This decision does not change your youngest child's eligibility.

Your youngest child's enrollment in her MMC plan properly ended as of September 30, 2016.

The effective date of your youngest child's CHP plan is November 1, 2016.

Your youngest child is not eligible for retroactive Medicaid for October 2016.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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)

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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 مجاناً.

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।

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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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerE 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 کرم 1-855-355-5777 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.

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