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

Notice of Decision

Decision Date: April 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014857

[redacted]

Dear [redacted]

On April 6, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 13, 2017 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: April 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014857

[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 you and your spouse were eligible to receive up to $133.00 per month in advance payments of the premium tax credit (APTC), effective February 1, 2017?

Did NYSOH properly determine that you and your spouse were not eligible for cost-sharing reductions?

Did NYSOH properly determine that you and your spouse were not eligible for the Essential Plan?

Did NYSOH properly determine that you and your spouse were not eligible for Medicaid?

Did NYSOH properly determine that your children were eligible to enroll in Child Health Plus (CHP) with a monthly premium of $60.00 each, effective February 1, 2017?

Did NYSOH properly determine that your children were not eligible for Medicaid?

Procedural History

On October 18, 2016, NYSOH issued a renewal notice stating that it was time to renew your application for health insurance for 2017. That notice stated that,

based on information obtained from state and federal data sources, you and your spouse were eligible to receive APTC of up to $210.76 per month, effective January 1, 2017, and your two children were eligible to enroll in CHP with a monthly premium of $60.00 each, effective January 1, 2017. The notice directed you to select a health plan between November 16, 2016 and December 15, 2016.

On November 18, 2016, NYSOH issued a notice of enrollment confirmation, confirming your children's enrollment in a CHP plan with a total monthly premium of $120.00, beginning January 1, 2017.

On November 22, 2016, you updated your application for health insurance.

On November 23, 2016, NYSOH issued a notice stating that your November 22, 2016 application had been reviewed, but that more information was needed to confirm the information in your application. The notice directed you to submit proof of your household income by December 7, 2016.

On November 28, 2016, NYSOH issued a disenrollment notice stating that your children's enrollment in CHP would end on January 1, 2017 because they were no longer eligible to enroll in that coverage.

On December 9, 2016, you updated your NYSOH application and uploaded documentation to your NYSOH account.

On December 10, 2016, NYSOH issued a notice stating that your December 9, 2016 application had been reviewed, but that more information was needed to confirm the information in your application. The notice directed you to submit income documentation by December 7, 2016.

On December 17, 2016, NYSOH issued a notice stating that the documentation you submitted had been reviewed, but that it did not confirm the information in your application. The notice directed you to submit household income documentation by January 6, 2017.

On December 21, 2016 and December 31, 2016, you uploaded documentation to your NYSOH account.

On January 13, 2017, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible to receive up to $133.00 per month in APTC, effective February 1, 2017, and that you were not eligible to receive cost-sharing reductions, or for the Essential Plan or Medicaid. The notice also stated that your children were eligible to enroll in CHP with a $60.00 monthly premium each, effective February 1, 2017, and that they were not eligible for Medicaid.

Also on January 13, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination, insofar as you were looking for your family to be eligible for a higher level of financial assistance through NYSOH.

On April 6, 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 through April 21, 2017, to allow you to submit supporting documents. On April 20, 2017, you uploaded documentation to your NYSOH account. The record is now closed.

Findings of Fact

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

1) You testified that you expect to file your 2017 taxes with a tax filing status of married filing jointly. You will claim two dependents on that tax return.

2) You are seeking insurance for yourself, your spouse, and your two children.

3) On November 22, 2016, you updated your NYSOH application, and indicated that your annual expected household income for 2017 was $15,964.00, consisting of earned income for your spouse.

4) On December 9, 2016, you updated your NYSOH application and indicate that your annual expected household income for 2017 was $15,600.00, consisting of earned income for your spouse.

5) Your NYSOH account reflects that, on December 9, 2016, you uploaded documentation to your NYSOH account consisting of the following:

    a. A copy of a [redacted] showing net profit of $5,557.00 for your spouse's business (Document [redacted]
    b. A copy of a [redacted] for your spouse showing nonemployee compensation of $16,089.75 (Document [redacted]).

6) Notes entered by a NYSOH agent in your NYSOH account on December 16, 2016 state, "Invalid proof of income. [redacted] submitted [redacted] from tax form, and [redacted]. Attested to self employment. Required documentation is full 2015-1040 signed and dated. Refer to acceptable documents list for additional acceptable income documents. Due date not extended."

7) Your NYSOH account reflects that, on December 21, 2016, you uploaded documentation to your NYSOH account consisting of the following:

a. A letter dated December 21, 2016, signed by you, stating that you are the caretaker of your two children (Document [redacted]);
b. A letter dated December 21, 2016, signed by you, stating that you have not been employed for the duration of 2016 (Document [redacted]).

8) Your NYSOH account reflects that, on December 31, 2016, you uploaded documentation to your NYSOH account consisting of the following:
   a. A copy of the first page of your 2015 joint tax return, showing adjusted gross income of $98,156.00 (Document [redacted]);
   b. A copy of the second page of your 2015 joint tax return, showing your, and your spouse's, signature and a date of September 21, 2016 (Document [redacted]).

9) On January 12, 2017, a NYSOH agent updated your application and listed annual household income of $95,874.00, consisting of $15,600.00 in earned income for your spouse, and another $80,667.00 in "additional income" under your spouse's name. The application also listed a deduction of $393.00.

10) You testified that this amount was not at all correct, as it was based on information from your 2015 tax return. You testified that the $95,874.00 amount was correct for 2015, based on your spouse's earned income, and distributions that you took from your 401K in that year.

11) You testified that you informed NYSOH that this information was not correct for 2016 and would not be correct for 2017, but were told that all you could do was file an appeal.

12) You testified that you have been taking distributions from your 401K to pay your mortgage and other expenses, as you have had no income. You testified that you took much less in distributions in 2016 than you did in 2015, though you were not sure of the exact amount at the time of the hearing.

13) You testified that you expect to take the same amount or less in 401K distributions in 2017.

14) You testified that you did not take any distributions in January or February 2017.

15) You testified that your spouse is self-employed, and that she receives a 1099 form at the end of the year.

16) You testified that your spouse generally averages between $15,000.00 and $18,000.00 in gross annual income, before any expenses are deducted.

17) You testified that your spouse had gross earnings of approximately $16,000.00 in 2016.

18) You testified that you expect her income to be about the same in 2017.

19) After the hearing, you uploaded the following documentation to your NYSOH account:

    a. A copy of a [redacted] showing that you received gross distributions of $16,485.15 in 2016, and that the taxable amount was $16,485.15 (Document [redacted]);
    b. A copy of a [redacted] showing that your spouse earned gross nonemployee compensation in 2016 of $18,131.75 ([redacted]);
    c. A one-page document signed by your spouse that states, "I, [redacted], had a gross income from self employment of $1,508.00 for January and $847.00 for February" (Document [redacted]).

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

20) Your 2015 tax return indicated a deduction of $785.00 for self-employment tax for your spouse. You testified that the amount will probably be about the same in 2017.

21) Your application states that you live in [redacted]

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

Applicable Law and Regulations

Advance Payments of Premium Tax Credit

APTC are generally available to a person who is eligible to enroll in a qualified health plan (QHP) and (1) expects to have a household income between 138% and 400% of the applicable federal poverty level (FPL), (2) expects to file a tax return and claim a personal exemption deduction for a person who meets the eligibility requirements to enroll in a QHP, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR §

155.305(f), 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

The maximum amount of APTC that can be authorized equals:

1) the cost of the health insurance premium for the taxpayer's coverage family in the second lowest cost silver plan offered through NY State of Health in the county where the taxpayer resides

minus

2) the taxpayer's expected contribution amount

(*see* 26 USC § 36B, 26 CFR § 1.36B-3).

The taxpayer's expected contribution amount is the amount that the taxpayer is expected to spend on health insurance premiums. The expected contribution for 2017 is set by federal law at 2.04% to 9.69% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc.2016-24).

In an analysis of APTC eligibility, the determination is based on the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested (45 CFR §§ 155.300(a), 155.305(f)(1)(i)). On the date of your application, that was the 2016 FPL, which is $24,300.00 for a four-person household (81 Federal Register 4036.).

For annual household income in the range of at least 300% but less than 400% of the 2016 FPL, the expected contribution is 9.69% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

People who use the APTC to help pay health insurance premiums must file a federal tax return and reconcile their expected income (stated on NYSOH application) with their actual income (stated on their federal income tax return). Those who take less tax credit in advance than they claim on the tax return may get the rest of it as an income tax refund or have their tax bill reduced. Those who take more tax credit in advance than they can claim on their tax return will owe the difference as additional income taxes (26 CFR § 1.36B-4).

<u>Cost-Sharing Reductions</u>

Cost-sharing reductions (CSR) are available to a person who (1) is eligible to enroll in a QHP through NYSOH, (2) meets the requirements to receive APTC, (3) is expected to have an annual household income that does not exceed 250% of the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level QHP (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable FPL or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or CHP as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your application, that was the 2016 FPL, which is $24,300.00 for a four-person household (81 Fed. Reg. 4036.).

A person who has a household income that is at or below 150% of the FPL has a $0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a $20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

Medicaid

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)).

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 $24,300.00 for a four-person household (81 Fed. Reg. 4036).

Child Health Plus

CHP is a sliding-scale-premium program for children who are in a household that is over income for regular Medicaid (*see* New York Public Health Law (NY PHL) § 2510 et seq. and 42 USC § 1397aa). Eligibility rules are set out in NY PHL § 2511(2), as well as in the NYS Department of Health 2008-2012 Contract and Plan Manual.

A child who meets the eligibility requirements for CHP may be eligible to receive a subsidy payment if the child resides in a household with a household income at or below 400% of the FPL (NY PHL § 2511(2)(a)(iii)). To be eligible to enroll in CHP with subsidy payments, a child must not be "eligible for medical assistance;" that is, must not be eligible for Medicaid (NY PHL § 2511(2)(b)).

The amount of the premium payment, if any, that must be made on behalf of a child who enrolls in a CHP plan depends upon the child's family household income (NY PHL § 2510(9)(d)). No payments are required for eligible children whose family household income is less than 160% of the FPL (NY PHL § 2510(9)(d)(1)). If the family household income is 160% or higher, premiums range from $9.00 per month to $60.00 per month (NY PHL § 2510(9)(d)).

The CHP premium is $9.00 per month for a child whose family household income is between 160% and 222% of the FPL, but no more than $27.00 per month per family (NY PHL § 2510(9)(d)(ii)).

The CHP premium is $15.00 per month for a child whose family household income is between 223% and 250% of the FPL, but no more than $54.00 per month per family (NY PHL § 2510(9)(d)(iii)).

The CHP premium is $30.00 per month for a child whose family household income is between 251% and 300% of the FPL, but no more than $90.00 per month per family (NY PHL § 2510(9)(d)(iv)).

The CHP premium is $45.00 per month for a child whose family household income is between 301% and 350% of the FPL, but no more than $135.00 per month per family (NY PHL § 2510(9)(d)(v)).

The CHP premium is $60.00 per month for a child whose family household income is between 351% and 400% of the FPL, but no more than $180.00 per child (NY PHL § 2510(9)(d)(vi)).

In an analysis of CHP 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 was $24,300.00 for a four-person household (81 Fed. Reg. 4036).

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 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 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 was $24,300.00 for a four-person household (81 Fed. Reg. 4036).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you and your spouse were eligible for an APTC of up to $133.00 per month.

A NYSOH agent updated your NYSOH application on January 12, 2017 to reflect annual household income of $95,874.00, and the eligibility determination relied upon that information.

You are in a four-person household. You expect to file your 2017 income taxes as married filing jointly and will claim two dependents on that tax return.

You reside in [redacted] where the second lowest cost silver plan available for a couple through NYSOH costs $906.77 per month.

An annual income of $95,874.00 is 394.54% of the 2016 FPL for a four-person household. At 394.54% of the FPL, the expected contribution to the cost of the health insurance premium is 9.69% of income, or $774.18 per month.

The maximum amount of APTC that can be approved equals the cost of the second lowest cost silver plan available through NYSOH for a couple in your county ($906.77 per month) minus your expected contribution ($774.18 per month), which equals $132.59 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you and your spouse to be eligible for up to $133.00 per month in APTC, based on the income entered by NYSOH into the application on January 12, 2017.

The second issue under review is whether you and your spouse were properly found ineligible for cost-sharing reductions. Cost-sharing reductions are available to a person who has a household income no greater than 250% of the FPL. Since a household income of $95,874.00 is 394.54% of the applicable FPL,

NYSOH correctly found you to be ineligible for cost sharing reductions, based on the income information that they utilized.

The third issue under review is whether NYSOH properly determined that you and your spouse were ineligible for the Essential Plan.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $24,300.00 for a four-person household. Since an annual household income of $68,874.00 is 394.54% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan, based on the income information that they utilized.

The fourth issue under review is whether NYSOH properly determined you and your spouse were ineligible for Medicaid.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $24,300.00 for a four-person household. Since $95,874.00 is 394.54% of the 2016 FPL, NYSOH properly found you and your spouse to be ineligible for Medicaid on an expected annual income basis, based on the income information that they utilized.

The fifth issue under review is whether NYSOH properly determined that your children were eligible to enroll in CHP with a $60.00 monthly premium each, effective February 1, 2017.

A child is eligible to enroll in CHP if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the FPL. Households with an income between 351% and 400% of the FPL are responsible for a $60.00 per month CHP premium payment. On the date of your application, the relevant FPL was $24,300.00 for a four-person household. Since $95,874.00 is 394.54% of the 2016 FPL, NYSOH properly found your child to be eligible for CHP with a $60.00 per month premium payment, based on the income information that they utilized.

The sixth issue under review is whether NYSOH properly determined that your children were not eligible for Medicaid.

Medicaid can be provided through NYSOH to children between the ages of one and nineteen who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 154% of the FPL for the applicable family size. Since $95,874.00 is 394.54% of the 2016 FPL for a four-

person household, NYSOH properly found your child to be not eligible for Medicaid, based on the income information utilized by NYSOH.

However, you indicated during the hearing that you never attested that your household income would be $95,874.00 in for 2017. Your NYSOH account indicates that your November 22, 2016 application update and December 9, 2016 application update indicated annual expected income for 2017 of $15,964.00 and $15,600.00, respectively. As a result, you and your family were placed into a “Medicaid pending” status, and NYSOH requested proof of your income.

You testified that you tried to explain to NYSOH employees whom you spoke with that your income was now much less than it was in 2015, but that the employees told you that the determination was based on your 2015 income, and there was nothing that could be done, except to file an appeal. Indeed, notes entered by a NYSOH employee on December 16, 2016 indicate that NYSOH determined that you needed to submit a copy of your 2015 tax return to substantiate your income. Had you been given correct information and been asked for appropriate documentation, your eligibility determination would have been based on the proper income information for 2017.

After the hearing, you submitted documentation showing that, in 2016, you received $16,485.15 in distributions from your retirement account, and that your spouse received $18,131.75 in self-employment income. You testified that you believe your 2017 income will be the same. You also attested to an approximately $785.00 deduction for self-employment tax for your spouse. Therefore, based on this information, your expected annual income is $33,831.90 for 2017.

It is noted that your spouse’s 2015 self-employment income was reduced from $16,089.75 to $5,557.00 in reportable, taxable income, per your [redacted]. However, no information is available in the record regarding what portion of your spouse’s 2016 income was/will be reported on your 2016 tax return. Therefore, the full amount of her [redacted] must be used at this time. Should you wish to update your NYSOH application and provide information showing how much of your spouse’s [redacted] will be included on your 2016 tax return, you will need to contact NYSOH to do so.

Since the January 13, 2017 eligibility determination was based on incorrect information, it must be RESCINDED.

Your case is RETURNED to NYSOH to redetermine your family’s eligibility for financial assistance, based on a household of four with an expected annual income for 2017 of $33,831.90, residing in [redacted] Your new eligibility will be effective February 1, 2017.

NYSOH will promptly issue a written notice informing you of your family's new eligibility for financial assistance.

Decision

The January 13, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to determine your family's eligibility for financial assistance, effective February 1, 2017, based on a household of four with an expected annual income of $33,831.90, residing in [redacted]

NYSOH is directed to issue a notice in writing to inform you of your household's new eligibility.

Effective Date of this Decision: April 28, 2017

How this Decision Affects Your Eligibility

The January 13, 2017 eligibility determination was incorrect, as it was based on incorrect income information.

Your case is being sent back to NYSOH to redetermine your family's eligibility for financial assistance, effective February 1, 2017, based on the income information your provided during, and after, the hearing.

You will be notified in writing of NYSOH's determination regarding your family's eligibility for financial assistance for 2017.

Should you wish to provide additional information regarding how much of your spouse's [redacted] income was reportable on your 2016 federal tax return, you must contact NYSOH with this information.

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.

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).

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):

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 January 13, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to determine your family's eligibility for financial assistance, effective February 1, 2017, based on a household of four with an expected annual income of $33,831.90, residing in [redacted]

NYSOH is directed to issue a notice in writing to inform you of your household's new eligibility.

The January 13, 2017 eligibility determination was incorrect, as it was based on incorrect income information.

Your case is being sent back to NYSOH to redetermine your family's eligibility for financial assistance, effective February 1, 2017, based on the income information your provided during, and after, the hearing.

You will be notified in writing of NYSOH's determination regarding your family's eligibility for financial assistance for 2017.

Should you wish to provide additional information regarding how much of your spouse's [redacted] income was reportable on your 2016 federal tax return, you must contact NYSOH with this information.

Legal Authority

We are sending you this notice 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 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.

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.

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).