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

Notice of Decision

Decision Date: June 20, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015242

[redacted]

Dear [redacted],

On April 27, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 28, 2017 eligibility determination 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 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).

This page intentionally left blank.

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: June 20, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015242

[redacted]

Issues

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

> Did NY State of Health properly determine you were eligible to receive $0.00 per month in advance payments of the premium tax credit, effective March 1, 2017?
>
> Did NY State of Health properly determine you were not eligible for cost-sharing reductions?
>
> Did NY State of Health properly determine you were not eligible for the Essential Plan?
>
> Did NY State of Health properly determine you and your children were not eligible for Medicaid as of January 27, 2017?
>
> Did NY State of Health properly determine your children were eligible for Child Health Plus with a $30.00 monthly premium each, effective March 1, 2017?

Procedural History

NYSOH received an updated application for financial assistance with health insurance for you and both your children on January 27, 2017. That day, a preliminary eligibility determination was prepared stating you were eligible to receive $0.00 in advance payments of the premium tax credits (APTC), for a limited time, effective March 1, 2017. The preliminary determination also found

your children eligible to enroll in Child Health Plus with a $30.00 monthly premium each, effective March 1, 2017.

Also on January 27, 2017, you spoke to NYSOH's Accounts Review Unit and appealed the eligibility determination insofar as you were not eligible for an increased level of financial assistance.

On January 28, 2017, NYSOH issued a notice of eligibility determination, based on the January 27, 2017 application, stating you were eligible to receive $0.00 in APTC, effective March 1, 2017. The notice indicated you were not eligible for Medicaid or the Essential Plan because the annual household income provided of $59,124.00 was over the allowable income limit for those programs. Additionally, that notice stated your children were eligible to enroll in Child Health Plus, effective March 1, 2017, with a $30.00 monthly premium. The notice indicated your children were not eligible for Medicaid, because your household income was over the allowable limit.

Also on January 28, 2017, NYSOH issued an enrollment notice confirming your enrollment in a full cost qualified health plan, effective March 1, 2017. Additionally, the notice confirmed your children's enrollment in a Child Health Plus plan with a $60.00 combined monthly premium, effective March 1, 2017.

On February 1, 2017, NYSOH issued an eligibility determination notice confirming you had been granted Aid to Continue (ATC) in your Essential Plan, effective February 1, 2017. You subsequently enrolled in an Essential Plan, pursuant to your grant of ATC, with coverage effective February 1, 2017.

On April 27, 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 to allow you to submit supporting documents.

On May 13, 2017, the Appeals Unit received the requested documentation and it was incorporated into the record as Appellant's Exhibit #1, the record closed thereafter.

Findings of Fact

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

1) You testified you moved to New York in October 2016. You testified you began earning approximately $800.00 gross per week at that time.

2) On November 7, 2016, four applications for financial assistance with health insurance for you and your oldest child were submitted on your behalf. Each application listed your annual household income amount as

$0.00. You testified this was not accurate, but that the Certified Application Consultant that submitted the application on your behalf told you to list $0.00 as your household income because you had been in the country for less than a year.

3) Your account confirms NYSOH issued eligibility determination notices to each application submitted on November 7, 2016, each determined you eligible for the Essential Plan and your oldest child eligible for Medicaid. Subsequently you both enrolled in health plans.

4) According to NYSOH's records, the November 8, 2016 eligibility determination and enrollment confirmation notices were returned to NYSOH as undeliverable on November 18, 2016.

5) On January 5, 2017, your youngest child was added to your account and an updated application was submitted on behalf of you and your two children. Your account confirms the annual household income amount listed in this application was $0.00.

6) Based on the information in that application, you were again determined eligible for the Essential Plan and your children were determined eligible for Medicaid.

7) According to your account, on January 20, 2017, NYSOH marked your mailing address invalid.

8) You and your children were determined ineligible for health insurance through NYSOH and disenrolled from your health plans, effective January 31, 2017, based on your invalid mailing address.

9) On January 27, 2017, you contacted NYSOH and an updated application for financial assistance with health insurance was submitted on behalf of you and your children. That application listed your annual household income as $59,124.00 consisting of $1,137.00 in gross weekly earnings from one job. You testified this amount was accurate. However, you testified that your paycheck sometimes varies depending on the hours you work.

10) You submitted the following four weekly paystubs:

    a. Paystub with check date of January 6, 2017 in the gross amount of $1,174.14

    b. Paystub with check date of January 13, 2017 in the gross amount of $1,407.59

c. Paystub with check date of January 20, 2017 in the gross amount of $1,174.14

d. Paystub with check date of January 27, 2017 in the gross amount of $1,174.14

11) You testified, and your application indicates, you expect to file your 2017 tax return with a tax filing status of head of household and you will claim two dependents on that tax return.

12) You testified and your application indicates you will not be taking any deductions on your 2017 tax return.

13) Your application indicates you live in Queens County.

14) You testified you and your children are Permanent Resident Card holders. Documents submitted confirm you and your oldest child were issued Permanent Resident Cards on October 3, 2016 and your youngest child was issued a card on December 24, 2016.

15) Your account confirms your children were ages [redacted] at the time of the application.

16) You testified you are currently pregnant. You testified you became pregnant in February 2017 and your anticipated due date is [redacted]. You testified you were not pregnant in January 2017.

17) You testified you are a single mother and you have extensive living expenses such as rent, utilities, and child care. You testified you cannot afford to pay your living expenses as well as healthcare premiums.

18) You testified you are seeking eligibility for an increased level of financial assistance including a higher APTC, Medicaid, or the Essential Plan for yourself. You also testified you are seeking eligibility for Medicaid for your children or a lower Child Health Plus plan premium.

19) Your account confirms you have been enrolled an Essential Plan since February 1, 2017 pursuant to a grant of Aid to Continue.

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

Applicable Law and Regulations

Household Composition

For purposes of advance premium tax credit (APTC) and cost-sharing reductions (CSR), the household size equals the number of individuals for whom the taxpayer is allowed a deduction under 26 USC § 151 for the taxable year, which typically includes: (1) the taxpayer, (2) his or her spouse, and (3) any claimed dependents (26 USC § 36B(d)(1)).

For purposes of Medicaid eligibility, however, 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).

Advance Payments of Premium Tax Credit

Advance payments of the 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 $20,160.00 for a three-person household (81 Federal Register 4036).

For annual household income in the range of at least 250% but less than 300% of the 2016 FPL, the expected contribution is between 8.21% and 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).

Cost-Sharing Reductions

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 federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus 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 $20,160 for a three-person household (81 Fed. Reg. 4036).

The Essential Plan is considered minimum essential coverage therefore, a person who is eligible for the Essential Plan is not eligible for any premium tax credit because they are eligible for minimum essential coverage through the individual market (*see* 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

Medicaid Eligibility

Adults: 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)).

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 2017 FPL, which is $20,420.00 for a three-person household (82 Fed. Reg. 8831).

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).

Child Health Plus

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 federal poverty level (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 Child Health Plus 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 2017 FPL, which was $20,420.00 for a three-person household (80 Federal Register 3236, 3237).

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income.

Legal Analysis

The first issue is whether NYSOH properly determined you were eligible for an APTC of $0.00 per month, effective March 1, 2017.

The application that was submitted on January 27, 2017 listed an annual household income of $59,124.00 and the eligibility determination relied upon that information.

During the hearing, you testified that the amount you provided in your application was correct. However, you testified that you have extensive living expenses such as rent, utilities, and childcare that should be considered when determining your eligibility for financial assistance with health insurance. Since the Internal Revenue Service rules do not allow living expenses such as rent, utilities, cable and phone to be deducted from the calculation of your adjusted gross income, they cannot be deducted when the NYSOH computes your modified adjusted gross income for APTC purposes. Therefore, NYSOH correctly determined your household income to be $59,124.00.

You are in a three-person household. You testified, and your application indicates, you expect to file your 2017 income taxes as head of household and will claim two dependents on that tax return.

You reside in Queens County, where the second lowest cost silver plan available for an individual through NYSOH costs $456.46 per month.

An annual income of $59,124.00 is 293.27% of the 2016 FPL for a three-person household. At 293.27% of the FPL, the expected contribution to the cost of the health insurance premium is 9.49% of income, or $467.57 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 an individual in your county ($456.46 per month) minus your expected contribution ($467.57 per month), which equals -$11.11 per month. Since your expected contribution, based on your annual income and household size, exceeds the cost of the second lowest cost silver plan available through NYSOH for an individual in your county, NYSOH correctly determined you eligible for $0.00 per month in APTC.

The second issue is whether you 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 $59,124.00 is 293.27% of the applicable FPL, NYSOH correctly found you to be ineligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined you 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 $20,160.00 for a three-person household. Since an annual household income of $59,124.00 is 293.27% of the 2016 FPL, NYSOH properly found you ineligible for the Essential Plan.

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

Medicaid can be provided through NYSOH to applications who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the applicable FPL for adults between the ages of 19 and 65 and at or below 154% of the applicable FPL for children at least one year of age but younger than nineteen.

On the date of your application, the relevant FPL was $20,420.00 for a three-person household. Since $59,124.00 is 289.54% of the 2017 FPL, NYSOH properly found you and your children ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

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

You submitted four weekly paystubs from pay dates in January 2017 evidencing you received gross income in the amount of $4,930.01 in the month of January 2017.

For you to be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $2,349.00 per month. Since the documentation you provided shows that you earned $4,930.01 in January 2017 you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

With regard to your children, to qualify for Medicaid on a monthly income basis the monthly household income cannot exceed 154% of the applicable monthly FPL, or $2,621.00. As the evidence establishes your household income for the month of January 2017 exceeded the monthly income limit, your children did not qualify for Medicaid on this basis.

It is noted that you testified you are currently pregnant and that you have been pregnant since February 2017. According to the above cited regulations, your pregnancy increases your household size and the applicable FPL used to determined your Medicaid eligibility. Since you testified you were not pregnant at the time of the application at issue, your pregnancy does not affect your eligibility for the purposes of this decision. However, your pregnancy may affect subsequent eligibility determinations.

The fifth issue under review is whether NYSOH properly determined your children were eligible to enroll in Child Health Plus with a $30.00 per month premium, effective March 1, 2017.

As discussed above, you attested in your January 27, 2017 updated application that your annual expected income was $59,124.00 and the evidence established your children were in a three-person household as of the date of that application.

A child is eligible to enroll in Child Health Plus 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 251% and 300% of the FPL are responsible for a $30.00 per month Child Health Plus premium payment. On the date of your application, the relevant FPL was $20,420.00 for a three-person household. Since $59,124.00 is 289.54% of the 2017 FPL, NYSOH properly found your children to be eligible for Child Health Plus with a $30.00 per month premium payment each.

Since the January 28, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for $0.00 per month in APTC, ineligible for cost-sharing reductions, ineligible for the Essential Plan, you and your children were ineligible for Medicaid, and your children were eligible for Child Health Plus with a $30.00 per month premium payment each, it is correct and is AFFIRMED.

Decision

The January 28, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: June 20, 2017

How this Decision Affects Your Eligibility

You remain eligible for $0.00 in APTC.

You are ineligible for cost-sharing reductions.

You are ineligible for the Essential Plan.

You and your children are ineligible for Medicaid.

Your children are eligible for Child Health Plus with a $30.00 per month premium payment each.

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 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).

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 28, 2017 eligibility determination notice is AFFIRMED.

You remain eligible for $0.00 in APTC.

You are ineligible for cost-sharing reductions.

You are ineligible for the Essential Plan.

You and your children are ineligible for Medicaid.

Your children are eligible for Child Health Plus with a $30.00 per month premium payment each.

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).