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

Notice of Decision

Decision Date: May 17,2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015522

[redacted]

Dear [redacted],

On May 5, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 2, 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: May 17, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015522

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly determine that your child was not eligible for Medicaid for the months of November and December 2016, and January 2017?
>
> Did NYSOH properly determine that your child was eligible for Child Health Plus (CHP), effective March 1, 2017?

Procedural History

On November 9, 2016, you added your newborn child to your NYSOH account and filed for financial assistance with health insurance on her behalf.

On November 10, 2016, NYSOH issued a notice stating that your application had been reviewed, but that more information was needed to confirm the information in your application. The notice directed you to submit documentation of your income by November 24, 2016, and documentation of your child's citizenship status/Social Security number by February 7, 2017.

On November 18, 2016, your NYSOH account was updated.

On November 19, 2016, NYSOH issued a notice stating that your application was reviewed, but that more information was needed to confirm the information in your application. The notice directed you to submit income documentation by November 24, 2016.

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).

On December 6, 2016, NYSOH issued a notice of eligibility determination stating that your child was eligible to purchase a qualified health plan at full cost through NYSOH, effective January 1, 2017. The notice stated that she was not eligible for Medicaid, Child Health Plus, the Essential Plan, or tax credits because NYSOH did not receive documentation necessary to verify the income listed in your application.

On December 14, 2016, you updated your NYSOH account.

On December 15, 2016, NYSOH issued a notice stating that your application had been reviewed, but that more information was needed to confirm the information in your application. The notice directed you to submit documentation of your income by December 29, 2016.

Also on December 15, 2016, NYSOH issued a notice stating that you had submitted documentation, but that it could not be reviewed because it was received more than thirty days after the due date. The notice directed you to log into your account or call customer service to update your application.

On January 20, 2017, you updated your NYSOH application. On that day, you requested assistance paying for medical bills from November and December 2016 for your child.

On January 21, 2017, NYSOH issued a notice stating that your 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 January 28, 2017.

On February 2, 2017, NYSOH issued a notice stating that your child was eligible to enroll in CHP with a $30.00 monthly premium, effective March 1, 2017.

Also on February 2, 2017, NYSOH issued a notice stating that your child was not eligible for to have bills paid for the months of November and December 2016 because the program she was eligible for cannot pay for any care received in the past.

On February 3, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice, insofar as it denied retroactive Medicaid for the months of November and December 2016.

On February 4, 2017, NYSOH issued a notice of enrollment confirmation, confirming your child's enrollment in a CHP plan, beginning March 1, 2017.

On May 5, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, your father, [redacted], acted as

your authorized representative. Also during the hearing, the issue under review was amended to include your child's eligibility for retroactive Medicaid coverage in the month of January 2017. The record was developed during the hearing and held open through May 22, 2017, to allow you to submit supporting documents.

On May 10, 2017, NYSOH received the requested documents, which you submitted to the Appeals Unit by fax. No further documentation was received. The record is now closed.

Findings of Fact

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

1) You testified that you called NYSOH before your child was born and asked how to apply for health coverage, and were told that you needed to call back after she was born.

2) Your NYSOH account reflects that your child was born on [redacted], and you filed an application with NYSOH on her behalf on November 9, 2016.

3) You testified that you filed your 2016 federal income tax return as head of household with one dependent, and you expect to file your 2017 federal income tax return the same way.

4) Your application of November 9, 2016 listed expected annual income of $20,280.00. After you submitted this application, NYSOH directed you to submit documentation by November 24, 2016 to confirm your income.

5) On November 28, 2016, you faxed a six-page document to NYSOH consisting of the following:

   a. A bar code cover sheet;
   b. A copy of NYSOH's "Request for Additional Information – Documentation List;"
   c. A copy of four paystubs from "[redacted], [redacted]" for the following pay dates and gross amounts:
      i. 10/7/16 - $877.73;
      ii. 10/14/16 - $491.1.5, YTD $12,952.33;
      iii. 11/4/16 - $693.02; YTD $15,037.81;
      iv. 11/10/16 -$449.35

   (Document V16337FBF9001).

6) NYSOH uploaded this documentation to your NYSOH account on December 12, 2016.

7) On December 14, 2016, a NYSOH agent entered a note into your NYSOH account that states, “Observed expired income clock, invalid documents submitted after the clock expired. “Consumer to Reinstate Coverage” manual notice created, no further action taken.”

8) On December 15, 2016, NYSOH sent you a notice stating that your income documents had been received more than 30 days after the due date, and you would need to contact NYSOH to update your application.

9) You testified that you always tried to submit whatever documentation NYSOH was asking for, and they kept asking for more.

10) On December 21, 2016, you uploaded a letter from the NY State Insurance Fund dated November 29, 2016. The notice stated that your claim for disability benefits had been processed, and that your first claim payment should arrive in approximately seven to ten business days. The letter also stated that payments would be made through December 20, 2016, and that your weekly benefit rate would be $170.00 (Document [redacted]).

11) Also on December 21, 2016, you uploaded a letter, dated 12/21/2016 and signed by you, stating that you are on maternity leave and that your last day of work was 11/6/2016 (Document [redacted]).

12) You testified that your last day of work was November 6, 2016, and that you went back to work on January 1, 2017.

13) You testified that you received only two paychecks in November 2016, which you submitted in your fax of November 28, 2016.

14) You testified that you received disability payments in the month of December 2016 only, but that you are not sure how much you received in total.

15) On January 15, 2017, you uploaded documentation to your NYSOH account, including a paystub dated January 13, 2017 from [redacted] in the amount of $470.89 (Document [redacted]).

16) On January 18, 2017, you uploaded a signed letter from the [redacted], dated January 16, 2017. The letter states that you are an employee of [redacted] and that you were rehired on June 18, 2016 with

an hourly wage of $12.99. The letter also states that you were on maternity leave from November 8, 2016 through December 31, 2016 (Document [redacted]).

17) On February 1, 2017, a NYSOH employee updated your application. That employee entered a note in your NYSOH account stating "Valid proof of income. [redacted] submitted pay stubs from employer. Updated income from $20,280 to $44,766.28."

18) Your NYSOH account reflects that this NYSOH employee updated your application on February 1, 2017 using this income amount. The employee indicated that you work for [redacted] for $9.75 an hour, 40 hours per week, and that you earn a separate annual income of $24,486.28 from [redacted].

19) You testified that you are employed at one job, and were employed at only one job in November 2016 as well.

20) You testified that "[redacted]" is the same as [redacted], and the paystubs you submitted confirm this.

21) You testified that you believe your earnings will be less than $44,766.28 in 2017.

22) You testified that you work approximately 40 a week for $12.99 an hour, and eight hours a week for approximately $19.50 an hour.

23) You testified that you were left with unpaid medical bills for your child for the months of November and December 2016, and January 2017.

24) After the hearing, you faxed an eight-page document to the NYSOH Appeals Unit consisting of the following:

    a. A one-page fax cover sheet;
    b. A copy of the November 2016 letter from the NYS Insurance Fund;
    c. A copy of a letter from the NYS Insurance Fund dated May 5, 2017 stating that a copy of your disability payments information is attached;
    d. A one-page payment history from the NYS Insurance Fund for Claim [redacted] showing that you received a payment of $510.00 on December 1, 2016, and a payment of $340.00 on December 15, 2016;
    e. A copy of paystubs from [redacted] for the following dates and gross amounts:
        i. 1/13/17 - $470.89;
        ii. 1/20/17 - $764.53;

iii. 1/27/17 - $537.069, YTD - $1,872.51;
iv. 2/3/17 - $702.37

These documents are collectively marked and entered into the record as “Appellant’s Exhibit One.”

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

Applicable Law and Regulations

Medicaid for Children

A child who is under one year of age 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 223% 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 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 $16,020.00 for a two-person household (81 Fed. Reg. 4036).

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

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 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 $16,020.00 for a two-person household (81 Fed. Reg. 4036).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your child was not eligible for Medicaid for the months of November and December 2016, as well as whether your child was eligible for Medicaid in the month of January 2017.

You are in a two-person household; you file your taxes with a tax filing status of head of household, and claim one dependent on your tax return.

You submitted an application for financial assistance on January 20, 2017 and requested help in paying for medical bills for November and December 2016. At the hearing, you also requested help with medical bills from the month of January 2017. The record reflects that this request was made on behalf of your child, who was born on [redacted], and is and was therefore under one year of age.

When an individual files an initial application for Medicaid, his or her eligibility for retroactive Medicaid depends on the date of application. To this end, it does not matter whether 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 November, December, and January, your child would have needed to meet the non-financial criteria and have an income no greater than 223% of the FPL, which is $2,978.00 per month. There is no indication in the record that your child would have been ineligible for Medicaid based on non-financial criteria during November, December, and January.

You testified that you received two paychecks in November 2016, and that your last day of work was November 6, 2016. You uploaded paystubs dated November 4, 2016 and November 10, 2016 for gross pay amounts of $693.02 and $449.35, respectively. You also uploaded a letter from your employer confirming that you were on maternity leave as of November 8, 2016. Therefore, the record indicates that in the month of November 2016, you had a monthly household income of $1,142.37.

You testified that you did not work at all in December 2016, and the letter from your employer confirms that you were out on maternity leave through December 31, 2016. You testified that you did receive disability payments in December, and after the hearing, you faxed a payment history to the appeals unit showing that you received a total of two disability payments, and that these payments totaled $850.00. Therefore, the record indicates that, in the month of December 2016, you had a monthly household income of $850.00.

You testified that you went back to work on January 1, 2017. After the hearing, you provided paystubs. The last check you received in January, on January 27, 2017, shows year-to-date gross earnings of $1,872.51. Therefore, the record indicates that, in the month of January 2017, you had a monthly household income of $1,872.51.

Since the February 2, 2017 notice of eligibility determination found your child was not eligible for Medicaid for November 1, 2016 to December 31, 2016, because the program she was eligible for cannot pay for any care she received in the past, this notice is RESCINDED.

Since the record now contains a more accurate representation of what your income was for the months of November, December, and January, your case is RETURNED to NYSOH to consider your request for retroactive coverage for your child for the months of November 2016, December 2016, and January 2017, based on a household size of two people and household income of: $1,142.37 in November; $850.00 in December; and $1,872.51 in January. NYSOH is directed to utilize an income standard of 223% of the FPL, as your child is under one year of age.

The second issue under review is whether NYSOH correctly determined that your child was eligible for CHP, effective March 1, 2017.

CHP is a sliding-scale-premium program for children who are in a household that is over income for regular Medicaid. 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. 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.

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. The CHP premium is $30.00 per month for a child whose family household income is between 251% and 300% of the FPL.

The application that you submitted on January 20, 2017 listed an annual expected income of $20,280.00. You testified that you work for one employer, [redacted]), and that you earn $12.99 an hour for 40 hours a week, and time and a half for eight hours of overtime that you usually work per week. After you updated your application in January 2017, you also uploaded one paystub from January 13, 2017 for $470.89.

On February 1, 2017, an employee from NYSOH used your paystub from January 13, 2017 to calculate an expected annual income of $24,286.28 (arrived at by multiplying $470.89 times 52 weeks). However, it appears that this NYSOH employee believed that [redacted] and [redacted] were two separate

jobs. Therefore, the application also indicated that you worked at [redacted] for $9.75 an hour, 40 hours per week. When these two figures were added together, they totaled $44,766.28. Therefore, the February 2, 2017 eligibility determination finding that your child was eligible for CHP with a $30.00 monthly premium was incorrect, as it was based on an incorrect income amount.

After the hearing, you provided four consecutive paystubs from January 13, 20, and 27, and February 3, 2017. These paystubs combine for an average weekly wage of $643.72, or an annual salary of $33,473.44.

Therefore, your case is RETURNED to NYSOH to redetermine your child's eligibility for financial assistance, based on a household of two with an expected annual income of $33,473.44.

Since you have already paid CHP premiums and utilized your child's CHP coverage, any resulting eligibility change will not be retroactive, but will be effective as of July 1, 2017.

Decision

The February 2, 2017 eligibility determination stating that your child is not eligible for retroactive Medicaid because the program she is eligible for cannot pay for care received in the past is RESCINDED.

Your case is RETURNED to NYSOH to determine your child's eligibility for retroactive Medicaid for the months of November and December 2016, and January 2017, based on a household of two and the following income amounts, utilizing an eligibility standard of 223% of the FPL:

- November 2016: $1,142.37
- December 2016: $850.00
- January 2017: $1,872.51.

Your case is RETURNED to NYSOH to redetermine your child's ongoing eligibility for financial assistance, based on a household of two with an expected annual income of $33,473.44. This eligibility will be effective as of July 1, 2017.

NYSOH is directed to notify you in writing of your child's eligibility for retroactive Medicaid and for ongoing financial assistance.

Effective Date of this Decision: May 17, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your child's eligibility. Your case is being sent back to NYSOH to redetermine your child's eligibility for retroactive Medicaid in the months of November and December 2016, and January 2017.

Your case is also being sent back to redetermine your child's eligibility for ongoing financial assistance, based on the fact that you are in a household of two, working one job with an expected annual income of $33,473.44.

Since you have already paid CHP premiums and utilized your child's CHP coverage, her new eligibility will be effective as of July 1, 2017.

If You Disagree with this Decision (Appeal Rights)

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

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

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

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

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

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

- By fax: 1-877-369-0129

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

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

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 February 2, 2017 eligibility determination stating that your child is not eligible for retroactive Medicaid because the program she is eligible for cannot pay for care received in the past is RESCINDED.

Your case is RETURNED to NYSOH to determine your child's eligibility for retroactive Medicaid for the months of November and December 2016, and January 2017, based on a household of two and the following income amounts, utilizing an eligibility standard of 223% of the FPL:

- November 2016: $1,142.37
- December 2016: $850.00
- January 2017: $1,872.51.

Your case is RETURNED to NYSOH to redetermine your child's ongoing eligibility for financial assistance, based on a household of two with an expected annual income of $33,473.44. This eligibility will be effective as of July 1, 2017.

NYSOH is directed to notify you in writing of your child's eligibility for retroactive Medicaid and for ongoing financial assistance.

This is not a final determination of your child's eligibility. Your case is being sent back to NYSOH to redetermine your child's eligibility for retroactive Medicaid in the months of November and December 2016, and January 2017.

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).

Your case is also being sent back to redetermine your child's eligibility for ongoing financial assistance, based on the fact that you are in a household of two, working one job with an expected annual income of $33,473.44.

Since you have already paid CHP premiums and utilized your child's CHP coverage, her new eligibility will be effective as of July 1, 2017.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[redacted]

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).