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

Notice of Decision

Decision Date: June 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015611

[redacted]

Dear [redacted]

On May 18, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 1, 2017 eligibility determination notices.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the Account ID at the top of this notice.

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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

Decision

Decision Date: June 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015611

[redacted]

Issues

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

> Did NY State of Health properly determine that you were eligible to receive up to $334.00 per month in advance payments of the premium tax credit, effective March 1, 2016?
>
> Did NY State of Health properly determine that you were eligible for cost-sharing reductions?
>
> Did NY State of Health properly determine that you were ineligible for the Essential Plan, effective March 1, 2017?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid retroactively from October 1, 2016 through October 31, 2016?

Procedural History

On November 1, 2016, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for October 2016.

On November 2, 2016, NY State of Health (NYSOH) issued an eligibility determination notice, based on your November 1, 2016 application, stating that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium for a limited time, effective December 1, 2016. That notice also stated that you must provide proof of income by January 30, 2017 to confirm your eligibility.

Also on November 2, 2016, NYSOH issued a plan enrollment notice confirming your enrollment in the Essential Plan.

On November 16, 2016 and December 16, 3016, you submitted two bi-weekly paystubs dated November 10, 2016 and December 9, 2016, respectively, which were subsequently validated by NYSOH on January 31, 2017 (*see* Documents [redacted] and [redacted]).

On February 1, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive an advance payment of the premium tax credit (APTC) in an amount of up to $334.00, effective March 1, 2017. That notice also stated that you are not eligible for the Essential Plan because your household income is over the threshold for that plan.

Also on February 1, 2017, NYSOH issued a disenrollment notice stating that your Essential Plan would end effective February 28, 2017.

Also on February 1, 2017, NYSOH issued an eligibility determination notice stating that you were ineligible for help with paying medical bills for the period of October 1, 2016 through October 31, 2016 because the program you are eligible for cannot pay for any care you received in the past.

On February 7, 2017, you spoke to NYSOH's Account Review Unit and appealed the February 1, 2017 eligibility determination notice insofar as you were no longer eligible for the Essential Plan, effective February 28, 2017.

On February 10, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan with a $20.00 monthly premium for a limited time, effective March 1, 2017, as aid to continue until a decision could be made on your appeal.

On May 18, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Your request to amend your appeal to include the denial of retroactive Medicaid coverage for the month of October 2016 was granted and testimony was received on this issue.

The record was developed during the hearing and held open to June 1, 2017, to allow you to submit supporting documents. On May 24, 2017, you submitted a copy of two bi-weekly paystubs dated October 14, 2016 and October 28, 2016, along with your NYS income tax return for 2016. These documents were made part of the record as "Appellant's Exhibit A". No further documentation was received as of June 1, 2017 and the record was closed that day.

Findings of Fact

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

1) Your application states that you expect to file your taxes using a tax filing status of single, and will claim no dependents on that tax return. You testified that you expect to file your taxes using a tax filing status of single and claim one dependent on your tax return.

2) You testified that you are seeking reinstatement into the Essential Plan as of March 1, 2017 and retroactive Medicaid for the month of October 2016.

3) The application that was submitted on January 31, 2017 listed an annual household income of $26,665.60, based upon NYSOH's calculation utilizing the paystubs you submitted on November 16, 2016 and December 16, 2016.

4) On May 24, 2017, you submitted a copy of your bi-weekly paystubs dated October 14, 2016 and October 28, 2016, along with your 2016 NYS income tax return.

5) Your 2016 NYS income tax return shows that you filed your taxes utilizing a tax filing status of single, and claimed one dependent on that return. These documents also show that you earned $24,409.00 in earned income in 2016 (*see* Appellant's Exhibit A, [redacted]). Youi expect your income to be comparable in 2017.

6) The documentation you submitted on May 24, 2017 further show that in October 2016, your gross household income was $2,004.31, consisting of earned income of $970.06 gross wages paid to you on October 14, 2016 and $1,304.25 gross wages paid to you on October 28, 2016 (*see* Appellant's Exhibit A, [redacted]).

7) According to your NYSOH account and your testimony, you do not plan on taking any deductions on your tax return.

8) According to your NYSOH account and your testimony, you reside in Otsego County, New York.

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

Applicable Law and Regulations

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 2016 is set by federal law at 2.03% to 9.66% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc. 2014-37, IRS Rev. Proc. 2014-62).

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 $11,880.00 for a one-person household (81 Fed. Reg. 4036).

For annual household income in the range of at least 200% but less than 250% of the 2016 FPL, the expected contribution in 2017 is between 6.41% and 8.18% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2014-37, IRS Rev. Proc. 2014-62).

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 noncitizen 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 $11,880.00 for a one-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-healthprogram/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).

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 for Adults between the Ages of 19 and 65

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 $11, 880.00 for a one-person household and $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)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for an APTC of up to $334.00 per month.

The application that was submitted on November 1, 2016 listed an annual household income of $19,500.00. However, on January 31, 2017, NYSOH calculated your household income to be $26,665.60, based upon the paystubs you submitted and the eligibility determination relied upon that information.

Your application states that you expect to file your 2017 income taxes as head of household and will claim no dependents on that tax return. Therefore, for purposes of this analyses, NYSOH determined you had a one-person household.

You reside in Otsego County, where the second lowest cost silver plan available for an individual through NYSOH costs $496.57 per month.

An annual income of $26,665.60 is 224.46% of the 2016 FPL for a one-person household. At 224.46% of the FPL, the expected contribution to the cost of the health insurance premium in 2017 is 7.3% of income, or $162.22 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 ($496.57 per month) minus your expected contribution ($162.22 per month), which equals $334.35 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $334.00 per month in APTC, based on the income information and household size you provided in your application.

The second issue under review is whether you were properly found eligible 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 $26,665.60 is 224.46% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions, based on the information in your application.

Since the February 1, 2017 eligibility determination notice properly stated in part that you were eligible for APTC in an amount of up to $334.00 per month and eligible for cost sharing reductions, effective March 1, 2017, it is correct and must be AFFIRMED.

The third issue under review is whether NYSOH properly determined that you were ineligible for the Essential Plan, effective March 1, 2017.

The application that was submitted on January 31, 2017 listed annual household income of $26,665.60 in earnings from your employment in 2016, based on income documentation you submitted. Your application further stated that you expect to file your taxes with a tax filing status of single and will claim no dependents on that tax return. NYSOH relied on this information.

The Essential Plan is provided through NYSOH to individuals who meet the nonfinancial requirements and have a household modified adjusted gross income (MAGI) that is between 138% and 200% of the FPL for the applicable family size. The applicable FPL at the time of your January 31, 2017 application was $11,880.00 for a one-person household.

Since a household income of $26,655.00 is 224.46% of the applicable FPL for a one-person household, NYSOH properly found you to be ineligible for the

Essential Plan, based on the income information you provided. Therefore, the February 1, 2017 eligibility determination notice was correct in this regard and must be AFFIRMED.

However, you credibly testified and submitted documentation to prove, that the number of dependents and income listed on your application did not take into consideration that your child who is listed as a dependent on your tax return or the varied hours you work. Your submitted your 2016 NYS income tax return, which shows that you filed your taxes used a tax filing status of single, and claimed one dependent on that return. This document also shows that you received $24,409.00 in adjusted gross household income, consisting of income earned from employment, which you expect to be comparable in 2017.

Since the record now contains a more accurate representation of what your 2017 expected annual income is, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as an individual who resides in Otsego County, who is in a two-person household and has an expected household income of $24,409.00.

The final issue under review is whether NYSOH properly determined that you were not eligible for Medicaid retroactively for the period of October 1, 2016 through October 31, 2016.

You testified, and submitted documentation to prove, that you are in a two-person household because you file your taxes with a tax filing status of single and claim one dependent on your tax return.

You submitted an application for financial assistance on November 1, 2016 and requested help in paying for medical bills for October 1, 2016 to October 31, 2016.

When an individual files an initial application for Medicaid, his or her eligibility for retroactive Medicaid depends on the date of application. To this end, it does not 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.

You testified that you are seeking Medicaid from October 1, 2016 to October 31, 2016.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. To be eligible for Medicaid in October 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL for a two-person household size, which is $1,843.00 per month. There is nothing in the record to indicate that you would have been ineligible for Medicaid based on non-financial criteria during October 2016.

You testified that you are paid bi-weekly. You submitted a bi-weekly paystub dated October 14, 2016 for a gross pay amount of $970.06 and a bi-weekly paystub dated October 28,2016 for a gross pay amount of $1,304.25. Therefore, the record indicates that in the month of October 2016, you had a monthly household income of $2,004.31.

Since your income of $2,004.31 for October 2016 was more than the $1,843.00 monthly Medicaid limit, NYSOH properly determined that you were not eligible for Medicaid coverage during that month.

Therefore, the February 1, 2017 eligibility determination stating that you were not eligible for Medicaid in the month of October 2016, is AFFIRMED, but on the basis that your income was over the maximum allowable income limit to be eligible for Medicaid.

Decision

The February 1, 2017 eligibility determination notices are AFFIRMED.

Your case is RETURNED to NYSOH to re-determine your eligibility for financial assistance in 2017 based on an annual household income of $24,409.00 and a two-person household, for an individual residing in Otsego County.

NYSOH is directed to notify you of its redetermination and what further action may be required on your part, if applicable.

Effective Date of this Decision: June 12, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility. While your eligibility for financial assistance was based on your attestation of income and was correct as of your January 31, 2017 application, your case is being sent back to NYSOH to re-determine your eligibility for financial assistance in 2017 based on an annual

household income of $24,409.00 per year and a household size of two, for an individual residing in Otsego County.

At present, you have Essential Plan coverage as of March 1, 2017 as aid to continue during the appeal process. Your enrollment will not be disturbed until your eligibility is re-determined by NYSOH. NYSOH will notify you once this has been done and what further action may be required on your part, if applicable.

You are not eligible for Medicaid in the month of October 2016.

If You Disagree with this Decision (Appeal Rights)

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

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

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

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

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

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

- By fax: 1-877-369-0129

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

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 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 1, 2017 eligibility determination notices are AFFIRMED.

Your case is RETURNED to NYSOH to re-determine your eligibility for financial assistance in 2017 based on an annual household income of $24,409.00 and a two-person household, for an individual residing in Otsego County.

NYSOH is directed to notify you of its redetermination and what further action may be required on your part, if applicable.

This is not a final determination of your eligibility. While your eligibility for financial assistance was based on your attestation of income and was correct as of your January 31, 2017 application, your case is being sent back to NYSOH to re-determine your eligibility for financial assistance in 2017 based on an annual household income of $24,409.00 per year and a household size of two, for an individual residing in Otsego County.

At present, you have Essential Plan coverage as of March 1, 2017 as aid to continue during the appeal process. Your enrollment will not be disturbed until your eligibility is re-determined by NYSOH. NYSOH will notify you once this has been done and what further action may be required on your part, if applicable.

You are not eligible for Medicaid in the month of October 2016.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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.

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).

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।

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 नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu)اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

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).

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.

(Yiddish) אידיש

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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