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

Notice of Decision

Decision Date: July 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015851

[redacted]

Dear [redacted]

On June 9, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's failure to issue a timely eligibility determination and your request to backdate your Medicaid eligibility.

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

Decision

Decision Date: July 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015851

[redacted]

Issues

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

> Did NY State of Health (NYSOH) provide a timely determination of your eligibility in response to your November 13, 2015 application?
>
> Did NYSOH properly determine that your Medicaid eligibility began no earlier than December 1, 2016, with retroactive Medicaid being granted as of September 1, 2016?

Procedural History

On November 13, 2015, you submitted your initial application for health insurance with NYSOH. However, a system defect prevented you from completing your application and selecting a health plan. On November 16, 2015, a defect on the account was created by NYSOH on your behalf ([redacted]) in an attempt to correct the error message.

On November 14, 2015, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost through NYSOH because you met all of the eligibility requirements, effective December 1, 2015. The notice also stated that you qualified to select a health plan outside for the open enrollment period for 2015.

On December 6, 2016, NYSOH issued an eligibility redetermination notice stating that you were eligible to purchase a qualified health plan at full cost through NYSOH, effective January 1, 2017.

On December 6, 2016, the system defect created November 16, 2015 was resolved.

On December 7, 2016, NYSOH issued an eligibility redetermination notice, based on your December 6, 2016 updated application, stating that you were eligible for Medicaid, effective December 1, 2016.

On December 10, 2016, NYSOH issued a plan enrollment notice confirming that you were enrolled in the Medicaid Managed Care (MMC) plan you selected on December 9, 2016, and your coverage would start on January 1, 2017.

On January 13, 2017, NYSOH issued an eligibility redetermination notice stating the you are eligible for retroactive Medicaid for the three-month period of September 1, 2016 through November 30, 2016.

Also on January 13, 2017, NYSOH issued an eligibility redetermination notice, stating that you remain eligible for Medicaid, effective January 1, 2017.

On February 14, 2017, you spoke to NYSOH's Account Review Unit and appealed the denial of Medicaid coverage prior to September 1, 2016. You also appealed your inability to select a health plan following your November 13, 2015 application for health insurance.

On June 9, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open until June 26, 2017 for you to submit supporting documentation.

On June 27, 2017, the Appeals Unit received your 38-page facsimile submission. The submitted documents included a timeline of events you prepared, the Official Record of Benefit Payments for your Unemployment Insurance Benefits, your 2015 Individual Income Tax Return, your 2016 Individual Income Tax Return and redacted copies of your bank statements for November 2015, December 2015, January 2016, February 2016 and March 2016. These documents have been made part of the record collectively as "Appellant's Exhibit [redacted] The record was closed at that time.

Findings of Fact

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

1) You submitted an application to NYSOH for financial assistance on November 13, 2015. You testified that you were unable to complete your application and make a health plan selection because there was a system error and a "sorry message" was indicated on your application.

2) According to your NYSOH account, an incident was filed on November 16, 2015, in which a NYSOH representative indicates you had tried to update your application on November 13, 2015, but were unable to due to a "sorry message." A defect was filed that day as [redacted].

3) According to your NYSOH account, the defect was resolved on December 6, 2016, at which time your account was updated and you were determined eligible for Medicaid, effective December 1, 2016, and enrolled in a MMC plan, effective January 1, 2017.

4) According to your NYSOH account and your testimony, you were also found eligible for Medicaid retroactively for the period of September 1, 2016 through November 30, 2016.

5) According to the documents you submitted, you received Unemployment Insurance Benefits (UIB) of $425.00 per week for the period of November 9, 2015 through March 29, 2016. The Official Record of Benefit Payments statement indicates that you received $1,700.00 in November 2015, $1,700.00 in December 2015, $1,700.00 in January 2016, $1,700.00 in February 2016 and $2,125.00 in March 2016. (*see* Appellant's Exhibit [redacted]

6) According to your 2015 Individual Income Tax Return, your adjusted gross income for that tax year was $30,405.00, and you filed your tax return that year as single with no dependents

7) According to your 2016 Individual Income Tax Return, your adjusted gross income for that tax year was $13,395.00, and you filed your tax return that year as single with no dependents.

8) According to your NYSOH account, you reside in [redacted], New York.

9) You testified that you want your eligibility for Medicaid backdated to November 1, 2015, and you want health coverage in Medicaid for all of 2016 because you had to pay a tax penalty for that year.

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

Applicable Law and Regulations

<u>Medicaid</u>

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 November 13, 2015 application, that was the 2015 FPL, which is $11,770.00 for a one-person household (80 Federal Register 3236, 3237). For the 2016, the applicable budget period was the 2016 FPL which is $11,880 for a one-person household (81 Fed. Reg. 4036).

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).

Timely Notice of Medicaid Eligibility

When an individual applies for insurance through NYSOH, NYSOH must determine that person's eligibility promptly and without undue delay (45 CFR § 155.310(e)(1); 42 CFR § 435.1200(b)(3)(iii)).

To assess whether an eligibility determination was untimely, NYSOH must base the time period from the date of application to the date NYSOH notifies the applicant of its decision (45 CFR § 155.310(e)(2)). However, if the applicant submits an incomplete application or there is not sufficient information for NYSOH to make an eligibility determination, then NYSOH must notify that applicant that more information is needed to complete the application (45 CFR § 155.310(k)(1)).

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the application (42 CFR § 435.912).

Advance Payments of the Premium Tax Credit:

Advance payments of the premium tax credit (APTC) are available to a person who is eligible to enroll in a qualified health plan and (1) expects to have a household income between 138% and 400% of the applicable 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 qualified health plan, 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 2015 is set by federal law at 2.01% to 9.56% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1); IRS Rev. Proc. 2014-37)).

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 2014 FPL, which is $11,670.00 for a one-person household (79 Federal Register 3593, 3593).

For annual household income in the range of at least 250% but less than 300% of the 2015 FPL, the expected contribution is between 8.10% and 9.56% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

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 advanced premium tax credits, (3) is expected to have an annual household income that does not exceed 250% of the applicable FPL for the plan year for which coverage is requested, (4) is enrolled in a silver-level QHP (45 CFR § 155.305(g)(1)).

Legal Analysis

The first issue under review is whether NYSOH's provided you with a timely determination of your eligibility in response to your November 13, 2015 application.

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the completed application. To assess whether an eligibility determination was untimely, NYSOH must base the time period from the date of the completed application to the date NYSOH notifies the applicant of its decision.

The record reflects that NYSOH received your initial application for health insurance on November 13, 2015. The record further reflects that you were unable to complete your application or make a plan selection on that date due to a "sorry message". A defect was filed by NYSOH on your behalf on November 16, 2015 as [redacted], in an effort to correct the error message.

Although NYSOH issued an eligibility determination notice on November 14, 2015, because of the existing defect, you were unable to complete your application and select a qualified health plan.

The record further reflects that the system defect was not resolved until December 6, 2016 at which time you were allowed to update your application for health insurance and were determined eligible for Medicaid, effective December 1, 2016. On December 9, 2016, you selected a MMC plan and were enrolled with an effective start date of January 1, 2017.

On January 13, 2017, NYSOH issued an eligibility determination notice finding you eligible for retroactive Medicaid for the period of September 1, 2016 through November 30, 2016. The system would not allow any further backdating.

Therefore, the credible evidence of the record indicates you attempted to submit a completed application to NYSOH on November 13, 2015 and your eligibility was not determined until December 6, 2016, when the defect on your account was cleared. On December 6, 2016, you were found eligible for Medicaid, effective December 1, 2016, as stated in the December 7, 2016 eligibility determination notice. On January 13, 2017, you were found eligible for retroactive Medicaid through Fee-For-Service Medicaid for the months of September, October and November, 2016, as stated in the corresponding December 7, 2016 and January 13, 2017 eligibility determination notices.

As such, it is reasonable to conclude that NYSOH did not provide you with an eligibility determination until 368 days after your initial application was completed on November 13, 2015, rendering its December 6, 2016 and January 13, 2017 eligibility determination notices untimely.

Therefore, the analysis turns to what your eligibility should have been as of your November 13, 2015 application had NYSOH timely issued an eligibility determination.

According to your NYSOH account and your testimony you want to be eligible for Medicaid as of your November 13, 2015 application.

As such, the second issue under review is whether you would have been eligible for Medicaid as of your November 13, 2015 application.

You are in a one-person household for purposes of this analysis based on your testimony and your 2015 and 2016 federal tax returns showing that you filed your taxes both years as single and did not claim any dependents.

The record reflects that your total adjusted gross income during the 2015 tax year was $30,405.00, and your income during the months of November 2015 and December 2015 was $1,700.00 for each month from UIB payments.

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 November 13, 2015 application, that was the 2015 FPL, which is $11,770.00 for a one-person household (80 Fed. Reg. 3236, 3237).

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $11,770.00 for a one-person household. Since $30,405.00 is 258.33% of the relevant 2015 FPL, you would not have been eligible for Medicaid on an expected annual income basis in 2015, using the information provided in your 2015 income tax return.

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 a UIB statement that shows in November 2015 you received $1,700.00 in benefits.

To be eligible for Medicaid on a monthly basis, you would need to meet the non-financial criteria and have a monthly income no greater than 138% of the FPL, which is $1,354.00 per month. Since the documentation you provided shows that you earned $1,700.00 in November 2015, which exceeds the maximum allowable monthly income limit for that program, you did not qualify for Medicaid on the basis of monthly income as of the November 13, 2015 application.

The third issue under review is whether NYSOH should have determined you were eligible for advance payment of the premium tax credit for 2015.

It has already been established that you are in a one-person household. You submitted a copy of your 2015 income tax return that showed your household adjusted gross income was $30,405.00 in 2015, which will be relied upon in this analysis.

You reside in [redacted] where the second lowest cost silver plan available for an individual through NYSOH in 2015 cost $372.40 per month.

An annual income of $30,405.00 is 260.54% of the 2014 FPL for a one-person household. At 260.54% of the FPL, the expected contribution to the cost of the health insurance premium in 2015 is 8.41% of income, or $213.09 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 ($372.40 per month) minus your expected contribution ($213.09 per month), which equals $159.31 per month. Therefore, rounding to the nearest dollar and had NYSOH correctly determined your eligibility on November 13, 2015, you would have been eligible to enroll in a qualified health plan effective December 1, 2015, with APTC of up to $159.00 per month effective December 1, 2015.

The fourth issue is whether you should have been found eligible for cost-sharing reductions as of your November 13, 2015 application. 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 $30,405.00 is 260.54% of the applicable FPL, NYSOH would have found you to be ineligible for cost sharing reductions.

Based on the foregoing analysis, you should have been determined eligible to receive up to $159.00 per month in APTC, and ineligible for cost-sharing reductions or Medicaid. Therefore, your case is RETURNED to NYSOH to assist you in enrolling in a qualified health plan effective December 1, 2015 with APTC of $159.00 per month for the month of December 2015, at your option. You may elect to enroll into coverage within 60 days from the date of this decision.

You will be responsible for any premium payments less the $159.00 of APTC for the month of December 2015, should you decide to enroll in a qualified health plan for that month.

The fifth issue is what NYSOH should have determined you eligible for during the 2016 coverage year had there not been a defect on your account or had that defect been resolved earlier than December 6, 2016.

According to your 2016 income tax return, your household income for that tax year was $13,395.00.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size. While you were unable to submit an application for health insurance for coverage to begin in 2016, for the purposes of this analysis, the relevant FPL was $11,880.00 for 2016 for a one-person household. Since $13,395.00 is 112.75% of the 2016 FPL, you would have been eligible for Medicaid on an expected annual income basis, using the information provided in your 2016 income tax return.

Had you been allowed to submit an application for the 2016 coverage year, you would have been determined eligible for Medicaid starting January 1, 2016 for 12 months of continuous coverage.

It is noted, however, that NYSOH found you eligible for retro-Medicaid coverage beginning September 1, 2016.

Therefore, so as to bring your eligibility for Medicaid for 2016 in line with this decision, NYSOH's December 7, 2016 eligibility determination notice stating that your eligibility for Medicaid was effective as of December 1, 2016, is MODIFIED to state that your eligibility is effective January 1, 2016.

You case is RETURNED to NYSOH to change the effective date of your Medicaid eligibility from December 1, 2016 to January 1, 2016, and to notify you accordingly.

Sometimes after an appeal decision, an appellant can claim an exemption from the requirement to have health insurance. You might qualify for a health coverage exemption in 2016 if you didn't have health coverage while you were waiting for an appeal decision about coverage eligibility or savings and your appeal was eventually successful.

You must claim this exemption through the United States Department of Health and Human Services (HHS). Currently, NYSOH does not accept hardship exemption applications.

You will find the information you need to claim the exemption due to an appeal decision at https://www.healthcare.gov/exemptions-tool/#/results/2016/details/eligible-based-on-appeal. You can also call 1-800-318-2596.

Important: If you do not get a response from HHS to your exemption application in time to file your tax return, write the word "pending" in column "c" and file your return. If HHS does not approve your exemption, you will need to file an amended return later.

Decision

Your case is RETURNED to NYSOH to assist you in enrolling in a qualified health plan effective December 1, 2015 with APTC of $159.00 per month for the month of December 2015, at your option. You may elect to enroll into coverage within 60 days from the date of this decision.

You will be responsible for any premium payments less the $159.00 of APTC for the month of December 2015 should you decide to enroll in a qualified health plan for that month.

NYSOH's December 7, 2016 eligibility determination notice stating that your eligibility for Medicaid was effective as of December 1, 2016, is MODIFIED to state that your eligibility is effective January 1, 2016.

You case is RETURNED to NYSOH to change the effective date of your Medicaid eligibility from December 1, 2016 to January 1, 2016, and to notify you accordingly.

This decision does not affect any subsequent eligibility determinations made, enrollments confirmed, or notice issued by NYSOH.

Effective Date of this Decision: July 21, 2017

How this Decision Affects Your Eligibility

This decision does not change your current eligibility.

You were eligible to enroll in a qualified health plan effective December 1, 2015 with an APTC of $159.00 per month effective December 1, 2015.

Your case is RETURNED to NYSOH to assist you in enrolling in a qualified health plan, at your option, for the month of December 2015, within 60 days of the date of this decision. You will be responsible for any premium payments less the $159.00 of APTC for the month of December 2015, should you decide to enroll in a qualified health plan for that month.

By this decision, you are eligible for Medicaid effective January 1, 2016.

Your case is RETURNED to NYSOH to change the start date of your Medicaid eligibility from December 1, 2016 to January 1, 2016 and to notify you accordingly.

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

Your case is RETURNED to NYSOH to assist you in enrolling in a qualified health plan effective December 1, 2015 with APTC of $159.00 per month for the month of December 2015, at your option. You may elect to enroll into coverage within 60 days from the date of this decision.

You will be responsible for any premium payments less the $159.00 of APTC for the month of December 2015 should you decide to enroll in a qualified health plan for that month.

NYSOH's December 7, 2016 eligibility determination notice stating that your eligibility for Medicaid was effective as of December 1, 2016, is MODIFIED to state that your eligibility is effective January 1, 2016.

You case is RETURNED to NYSOH to change the effective date of your Medicaid eligibility from December 1, 2016 to January 1, 2016, and to notify you accordingly.

This decision does not affect any subsequent eligibility determinations made, enrollments confirmed, or notice issued by NYSOH.

This decision does not change your current eligibility.

You were eligible to enroll in a qualified health plan effective December 1, 2015 with an APTC of $159.00 per month effective December 1, 2015.

Your case is RETURNED to NYSOH to assist you in enrolling in a qualified health plan, at your option, for the month of December 2015, within 60 days of the date of this decision. You will be responsible for any premium payments less the $159.00 of APTC for the month of December 2015, should you decide to enroll in a qualified health plan for that month.

By this decision, you are eligible for Medicaid effective January 1, 2016.

Your case is RETURNED to NYSOH to change the start date of your Medicaid eligibility from December 1, 2016 to January 1, 2016 and to notify you accordingly.

Legal Authority

We are issuing this determination in accordance with 45 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).

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)

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).

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 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.

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