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

Notice of Decision

Decision Date: August 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016194

[redacted]

Dear [redacted]

On August 3, 2017, you and your authorized representative appeared by telephone at a hearing on your appeal of NY State of Health's February 17, 2017 disenrollment and February 24, 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 NY State of Health Account ID at the top of this notice.

Legal Authority

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

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

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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: August 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016194

[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 eligibility for and enrollment in your Medicaid Managed Care plan ended as of February 28, 2017?

Did NYSOH properly determine that you were eligible to receive up to $158.00 per month in advance payments of the premium tax credit, effective April 1, 2017?

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

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

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

Procedural History

On January 5, 2017, NYSOH issued a notice that it was time to renew your health insurance for the upcoming coverage year. That notice stated that, based on information from federal and state sources, NYSOH could not make a decision about whether you would qualify for financial help paying for your health coverage, and that you needed to update your account between January 16,

2017 and February 15, 2017 or you might lose the financial assistance you were currently receiving.

No updates were made to your account by February 15, 2017.

On February 17, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for health insurance through NYSOH. This was because you had not responded to the renewal notice and had not completed your renewal within the required time frame. Your eligibility ended March 1, 2017.

Also on February 17, 2017, NYSOH issued a disenrollment notice, stating that your enrollment in a Medicaid Managed Care plan would end on February 28, 2017.

On February 23, 2017, you submitted an application for financial assistance.

On February 24, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $158.00 in APTC for a limited time, effective April 1, 2017. That notice also stated that you were not eligible for cost-sharing reductions, the Essential Plan, or Medicaid because your income was over the allowable income limits for those programs. You were asked to provide proof of your income by May 24, 2017 to confirm the information in your application.

Also on February 24, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination, insofar as you were no longer eligible for Medicaid.

On March 1, 2017, NYSOH issued an eligibility determination stating that you were eligible for Medicaid, effective March 1, 2017, because you were granted aid to continue pending the outcome of your appeal.

Also on March 1, 2017, NYSOH issued an enrollment confirmation notice, stating that you were enrolled in a Medicaid Managed Care plan, effective March 1, 2017.

On August 3, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. You authorized [redacted] as your representative to assist you with your testimony. The record was developed during the hearing and held open up to August 18, 2017, to allow you to submit supporting documents.

As of August 18, 2017, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

1) Your NYSOH account indicates that you receive notices from NYSOH by regular mail.

2) You testified that you received the January 6, 2017 notice telling you that you needed to update the information in your NYSOH account to ensure that your coverage would not be interrupted.

3) You testified that you were unable to update your account because you sustained an injury in January 2017. You do not recall when you updated your account.

4) The record reflects that your updated application was submitted on February 23, 2017.

5) You testified that you expect to file your 2017 taxes with a tax filing status of single. You will claim no dependents on that tax return.

6) You are seeking insurance for yourself, specifically Medicaid with no gap in coverage.

7) The application that was submitted on February 23, 2017 listed annual household income of $37,600.00. You testified that this is not correct, and that you expect to earn significantly less in 2017.

8) You testified that you have multiple sources of income, including self-employment and multiple employers. You did not provide any documentation regarding your income.

9) You testified that your income from [redacted] was reduced in May 2017 when your employment was changed from five days a week to three.

10) You testified that your self-employment is operating at a loss.

11) You testified that you do not know what your monthly income was in February 2017.

12) Your application states that you will not be taking any deductions on your 2017 tax return. You testified that you will be taking business expense deductions on your tax return.

13) Your application states that you live in Westchester County.

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

Applicable Law and Regulations

Advance Payments of Premium Tax Credit

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

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

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

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 $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-health-program/basic-health-program.html).

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

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

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 2017 FPL, which is $12,060.00 for a one-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).

Annual Eligibility Redetermination

Generally, NYSOH must conduct annual eligibility redeterminations for qualified individuals who are seeking financial assistance through insurance affordability programs for the upcoming year, such as tax credits and cost-sharing reductions, Medicaid, or Child Health Plus. In such cases, NYSOH is required to request that the qualified individual provide updated income and family size information for use in an eligibility redetermination for the upcoming year (*see* 45 CFR § 155.335(a) and (b)).

NYSOH must send an annual renewal notice that contains the information by which NYSOH will use to redetermine a qualified individual's projected eligibility for that year (45 CFR § 155.335(c)(3)). If a qualified individual does not respond to the notice after a 30-day period, NYSOH must redetermine that individual's eligibility using the information and projected eligibility provided in the annual renewal notice (45 CFR § 155.335(g), (h)). NYSOH must ensure this redetermination is effective on the first day of the coverage year or in accordance with the rules specified in 45 CFR § 155.330(f) regarding effective dates,

whichever is later (45 CFR § 155.335(i)). The rules specified in 45 CFR § 155.330(f) are not pertinent here.

Redetermination During a Benefit Year

When an eligibility redetermination results in a change in the amount of APTC for a part of the benefit year, NYSOH must recalculate the amount of APTC in such a manner as to account for any advance payments already made (or not made) on behalf of the tax filer, such that the recalculated advance payment amount is projected to result in total advance payments for the benefit year that correspond to the tax filer's total projected premium tax credit for the overall benefit year (45 CFR § 155.330(g)).

Any change resulting from redeterminations during a benefit year should be made effective the first day of the month following the date of the notice of redetermination, except that redeterminations resulting from changes made after a date specified by the state, which can be no earlier than the 15th of the month, may not be made effective until the first day of the month after the month following the date of the notice of redetermination. (45 CFR § 155.330(f)(1) and (2). New York has specified that changes made after the 15th of a given month will take effect the month after the following month.

Legal Analysis

The first issue under review is whether NYSOH properly determined your eligibility for and enrollment in your Medicaid Managed Care plan ended as of February 28, 2017.

NYSOH must redetermine a qualified individual’s eligibility for health insurance and financial assistance to help pay for that health insurance annually. NYSOH must issue a renewal notice that contains the individual’s projected eligibility. If an individual does not respond to this notice, NYSOH must issue an eligibility determination for the upcoming coverage year based on the information contained in the renewal notice.

On January 5, 2017, NYSOH issued an annual renewal notice in your case. That notice stated that based on information from federal and state sources, NYSOH could not make a decision about whether or not you would qualify for financial help with paying for your health coverage. You were asked to update the information in your account by February 15, 2017 or the financial help you were receiving might end.

Because there was no timely response to this notice, your eligibility for financial assistance and your enrollment in a Medicaid Managed Care plan was terminated effective February 28, 2017.

You testified that you received the January 6, 2017 notice from NYSOH telling you that you needed to update the information in your NYSOH account. You testified that you were unable to update your application by February 15, 2017 because you sustained an injury in January 2017.

Therefore, NYSOH properly notified you of your annual renewal and that information in your NYSOH account needed to be updated in order to ensure your enrollment in your health plan and eligibility for financial assistance would continue.

Since no updates were made to your account prior to the renewal deadline, NYSOH properly terminated your enrollment in your Medicaid Managed Care plan. Accordingly, the February 17, 2017 disenrollment notice stating that your enrollment in your Medicaid Managed Care plan ended as of February 28, 2017 is AFFIRMED.

The second issue is whether NYSOH properly determined that you were eligible for an APTC of up to $158.00 per month.

The application that was submitted on February 23, 2017 listed an annual household income of $37,600.00 and the eligibility determination relied upon that information. Although you testified that you do not expect to earn $37,600.00 in 2017 and that your income has changed, you did not provide any documentation to support your testimony. Therefore, NYSOH properly determined your eligibility using a household income of $37,600.00.

You are in a one-person household. You expect to file your 2017 income taxes as single and will claim no dependents on that tax return.

You reside in Westchester County, where the second lowest cost silver plan available for an individual through NYSOH costs $461.49 per month.

An annual income of $37,600.00 is 316.5% of the 2016 FPL for a one-person household. At 316.5% of the FPL, the expected contribution to the cost of the health insurance premium is 9.69% of income, or $303.62 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 ($461.49 per month) minus your expected contribution ($303.62 per month), which equals $157.87 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $158.00 per month in APTC.

On February 23, 2017 you updated the information in your NYSOH account.

When an individual changes information in their application after the 15th of any month, NYSOH will make the redetermination that results from the change effective the first day of the second following month. Additionally, the date on which a qualified health plan can take effect depends on the day a person selects the plan for enrollment. A plan that is after the fifteenth day of a month goes into effect on the first day of the second following month.

Accordingly, your eligibility for $158.00 in APTC and enrollment in a qualified health plan would begin the first day of the second following month after February, that is April 1, 2017.

The third issue is whether you were properly found not 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 $37,600.00 is 316.5% of the applicable FPL, NYSOH correctly found you to be not eligible for cost sharing reductions.

The fourth issue under review is whether NYSOH properly determined that you were not eligible 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 $11,880.00 for a one-person household. Since an annual household income of $37,600.00 is 316.5% of the 2016 FPL, NYSOH properly found you to be not eligible for the Essential Plan.

The fifth issue is whether NYSOH properly determined that you were not eligible for Medicaid.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $12,060.00 for a one-person household. Since $37,600.00 is 311.77% of the 2017 FPL, NYSOH properly found you to be not eligible for Medicaid on an expected annual income basis, using the information provided in your application.

Since the February 23, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible to enroll in a qualified health plan, receive up to $158.00 per month in APTC, not eligible for cost-sharing reductions, not eligible for the Essential Plan and not eligible for Medicaid, effective April 1, 2017 it is correct and is AFFIRMED.

You testified that you do not expect to earn $37,600.00 in 2017, and that your self-employment business is operating at a loss. However, you did not provide any documentation to support your testimony. If the information in your application is not correct, please update your account accordingly.

Decision

The February 17, 2017 disenrollment notice is AFFIRMED.

The February 23, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: August 30, 2017

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

Your enrollment in your Medicaid Managed Care plan properly terminated as of February 28, 2017.

You remain eligible for up to $158.00 in APTC.

NYSOH properly determined you to be not eligible for cost-sharing reductions.

NYSOH properly determined you to be not eligible for the Essential Plan.

NYSOH properly determined you to be not eligible for Medicaid.

Your eligibility for enrollment in a qualified health plan, as well as your eligibility for APTC properly began as of April 01, 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 17, 2017 disenrollment notice is AFFIRMED.

Your enrollment in your Medicaid Managed Care plan properly terminated as of February 28, 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).

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The February 23, 2017 eligibility determination notice is AFFIRMED.

You remain eligible for up to $158.00 in APTC.

NYSOH properly determined you to be not eligible for cost-sharing reductions.

NYSOH properly determined you to be not eligible for the Essential Plan.

NYSOH properly determined you to be not eligible for Medicaid.

Your eligibility for enrollment in a qualified health plan, as well as your eligibility for APTC properly began as of April 1, 2017.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

[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)

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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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