



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: AP000000016348

[REDACTED]

Dear [REDACTED]

On June 9, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 4, 2017 eligibility determination and plan enrollment 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 at the top of this notice.

Legal Authority

We are sending you this notice in accordance with Code of Federal Regulation 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).

This page intentionally left blank.



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: AP000000016348



Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

Did NY State of Health (NYSOH) timely notify you of your newborn's eligibility?

Did NYSOH properly determine that your newborn was eligible for Child Health Plus (CHP), effective February 1, 2017?

Did NYSOH properly determine that your newborn was not eligible for Medicaid, effective January 1, 2017?

Did NYSOH properly determine that your newborn's CHP plan was effective February 1, 2017?

Did NYSOH properly determine that your newborn was not eligible for retroactive Medicaid from October 1, 2016 through January 31, 2017?

Procedural History

On October 19, 2016, NYSOH issued a notice, based on your October 18, 2016 application, stating that the income information in your application did not match what NYSOH received from state and federal data sources. That notice further stated that proof of income was needed by November 2, 2016, to confirm your newborn's eligibility.

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 November 3, 2016, you submitted two bi-weekly paystubs, dated September 30, 2016 and October 14, 2016 (see Document [REDACTED]). These paystubs were invalidated on November 23, 2016

On November 24, 2016, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal data sources. That notice further stated that proof of income was needed by November 17, 2016, to confirm your newborn's eligibility.

Also on November 24, 2016, NYSOH issued a notice stating that the information you provided did not confirm the information in your application. That notice further stated that additional proof of income was needed by December 17, 2016 to confirm your newborn's eligibility.

On December 17, 2016, you submitted a letter of attestation stating that your spouse is a full time stay-at-home mother, which was validated on January 3, 2017 (see Document [REDACTED]).

On December 29, 2016, NYSOH issued an eligibility determination notice stating that your newborn was eligible for a full price qualified health plan. This was because NYSOH did not receive the requested information to verify your income by the due date.

On January 3, 2017, you submitted two bi-weekly paystubs, dated December 15, 2016 and December 30, 2016 (see Documents [REDACTED] and [REDACTED]).

On January 4, 2017, NYSOH issued an eligibility determination notice, based on your updated application stating that your newborn was eligible to enroll in CHP with a \$15.00 monthly premium, effective February 1, 2017. The notice further stated that [REDACTED] was not eligible for Medicaid because your income of \$60,000.00 was over the allowable limit for that program.

Also on January 4, 2017, NYSOH issued a second eligibility determination notice stating that your newborn was not eligible for Medicaid from October 1, 2016 through December 31, 2016, because the program [REDACTED] is eligible for could not pay for any care [REDACTED] received in the past.

On February 28, 2017, you spoke to NYSOH's Account Review Unit and appealed that determination insofar as your newborn was eligible for coverage through Child Health Plus, and not eligible for Medicaid as of date of birth.

On June 9, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was held open to June 24, 2017 for you to submit supporting documents.

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 June 16, 2017, you submitted additional proof of income. These documents made part of the record as [REDACTED]. No further documentation was received by June 24, 2017 and the record closed that day.

Findings of Fact

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

- 1) You testified that you expect to file your 2017 tax return with a tax filing status of married filing jointly. You will claim your two children as dependents on that tax return.
- 2) The application that was submitted on October 18, 2016 listed annual household income of \$45,600.00, consisting of your earnings from employment. Because state and federal data sources did not match the income you attested to in that application, proof of income was needed to confirm your newborn's eligibility.
- 3) On November 3, 2016 and on all subsequent applications, you requested help paying for medical bills for your newborn.
- 4) On November 3, 2016, you submitted two bi-weekly paystubs, dated September 30, 2016 and October 14, 2016, which show that you are paid a bi-weekly salary of \$1,629.17 (see Document [REDACTED]). These documents were invalidated on November 23, 2016 as not being current.
- 5) On January 3, 2017, you updated your account and submitted two bi-weekly paystubs, dated December 15, 2016 and December 30, 2016. These documents show that you received \$5,000.00 in income in December 2016, and that you have a gross annual expected household income of \$60,000.00 for 2017 (see Documents [REDACTED] and [REDACTED]).
- 6) On June 16, 2017, you submitted proof of income documentation including your two paystubs for the month of October 2016. These documents show that in October 2016 you received a total gross income of \$3,953.89 (\$2,324.72 + \$1,629.17).

- 7) Your documentation further shows that in November 2016 you received a total income of \$5,300.00, calculated as follows:

\$ 47,311.19 year to date income as of 12/15/16
(\$ 2,500.00) less income as of 12/15/16
\$ 44,811.19
(\$ 39,511.19) year to date income as of 10/31/16
\$ 5,300.00 total November 2016 income

- 8) You testified that, as of December 15, 2016, you had received a raise in salary and were currently receiving \$2,500.00 bi-weekly in gross wages.
- 9) Your newborn was born on [REDACTED] and you updated your NYSOH account and application that same day.
- 10) Your application states that you will not be taking any deductions on your tax return.
- 11) Your application states that your family resides in [REDACTED], New York.
- 12) You testified that you would like your newborn to have insurance since her date of birth.

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

Applicable Law and Regulations

Verification Process

For all individuals, whose income is needed to calculate the household's eligibility, the Marketplace must request data that will allow NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i)). If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f)).

Timely Notice of 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).

Child Health Plus

Child Health Plus 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 20082012 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 \$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)).

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 \$24,600.00 for a four-person household (81 Fed. Reg. 4036).

The State of New York has provided that a child’s period of eligibility for CHP begins on the first day of the month during which a child is eligible. A child will become eligible on the first day of the next month, if the application is received by the 15th of the month; applications received after the 15th day of the month will

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).

be processed for the first day of the second following month (see e.g. State Plan Amendment (SPA) NY-14-0005, approved February 3, 2015 and effective January 1, 2014).

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 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 the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all persons whom such individual expects to claim as a tax dependent (42 CFR § 435.603(f)(1)).

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 was \$24,300.00 for a four-person household (81 Federal Register 4036).

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)).

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

Legal Analysis

The first issue under review is whether NYSOH's January 4, 2017 eligibility determination was timely.

In your October 18, 2016 application, you attested to an expected annual gross household income of \$45,600.00.

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).

Generally, when individuals' income cannot be verified by state and federal data sources to determine eligibility, NYSOH must attempt to resolve the inconsistency by giving the applicant the opportunity to submit satisfactory documentary evidence. If individuals are found eligible for Medicaid, their eligibility is effective the first day of the month in which they are found eligible. Because NYSOH could not verify your attested income on October 18, 2016, you were required to submit proof of income to confirm your family's eligibility.

In your case, on November 3, 2016, you submitted two bi-weekly paystubs, dated September 30, 2016 and October 14, 2016, which show that you were paid a bi-weekly salary of \$1,629.17. It appears that when you submitted this documentation you would have had in your possession a paystub dated October 31, 2016. As such, these documents were invalidated on November 23, 2016, as not being current and NYSOH issued a notice that your documentation was insufficient.

On December 17, 2016, December 30, 2016 and January 3, 2017, you updated your newborn's application and submitted additional documentation, including a letter of attestation that your spouse does not work and two current bi-weekly paystubs from your employment, dated December 15, 2016 and December 30, 2016, respectively. As of the December 30, 2016 submission, NYSOH was able to ascertain your household income.

NYSOH considers your application complete the date it receives sufficient documentation to confirm your household's income. As such, on January 4, 2017, NYSOH issued an eligibility determination notice stating that your newborn was eligible for Child Health Plus, effective February 1, 2017.

NYSOH must determine an applicant's eligibility within 45 days from the date of the completed application. Since your application was considered complete as of the date NYSOH received sufficient documentation to confirm your household's income, NYSOH's January 4, 2017 eligibility determination notice was timely, as it was issued within 45 days of December 30, 2016. Therefore, the January 4, 2017 eligibility determination notice stating that your child's eligibility for the CHP plan was effective February 1, 2017 was timely.

The second issue under review is whether NYSOH properly determined that your child was eligible to enroll in CHP with a \$15.00 per month premium.

According to the record, you expect to file a joint federal income tax return for the 2016 tax year and claim your two children as dependents. Therefore, your newborn, who is less than one year old, is in a four-person household for purposes of the following analyses.

In your completed January 3, 2017 application, you attested to, and submitted documentation to show, that you have an expected 2017 household income of \$60,000.00. NYSOH relied upon this information.

A child is eligible to enroll in CHP if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the FPL. Households with an income between 223% and 250% of the FPL are responsible for a \$15.00 per month CHP premium payment.

On the date of your application, the relevant FPL was \$24,600.00 for a four-person household. Since \$60,000.00 is 243.90% of the 2017 FPL, NYSOH properly found your child to be eligible for CHP with a \$15.00 per month premium payment.

The third issue under review is whether NYSOH properly determined that your child was not eligible for Medicaid as of January 1, 2017.

Medicaid can be provided through NYSOH to children less than one year old, who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 223% of the FPL for the applicable family size. Since \$60,000 is 243.90% of the 2017 FPL for a four-person household, NYSOH properly found your newborn to be not eligible for Medicaid.

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 credibly testified, and your income documentation reflects, that in January 2017, you received at least \$5,000.00 in earned income.

To be eligible for Medicaid, your newborn would need to meet the non-financial criteria and have an income no greater than 223% of the FPL, which is \$4,516.00 per month. Since you credibly testified that you earned a salary of \$5,000.00 in January 2017, and your submitted documentation corroborates your testimony, your newborn did not qualify for Medicaid based on monthly income in January 2017.

Since the January 4, 2017 eligibility determination properly stated that, based on the information you provided, your child was eligible for CHP with a \$15.00 per month premium and ineligible for Medicaid, it is correct and is AFFIRMED.

The fourth issue under review is the effective enrollment start date of your newborn's CHP plan.

According to your NYSOH account, you selected a CHP plan for your child on January 3, 2017, with an effective enrollment start date of February 1, 2017.

The date on which enrollment in a CHP plan can take effect depends on the day a person selects the plan for enrollment.

A plan that is selected from the first day to and including the fifteenth day of a month goes into effect on the first day of the following month. A plan that is selected from the sixteenth day of the month to the end of the month goes into effect on the first day of the second following month.

Since you selected a CHP plan for your newborn on January 3, 2017, [REDACTED] enrollment properly took effect on the first day of the month following January 2017; that is, on February 1, 2017.

Since NYSOH's January 4, 2017 plan enrollment notice properly states that your child's enrollment in [REDACTED] CHP plan is effective February 1, 2017, it is correct and AFFIRMED.

The fifth issue under review is whether NYSOH properly determined that your newborn was not eligible for retroactive Medicaid from October 1, 2016 through December 31, 2016.

The record reflects that you submitted an updated application on January 3, 2017, and requested help in paying for medical bills for October 1, 2016 to December 31, 2016.

On January 4, 2017, NYSOH issued a second eligibility determination notice stating that your newborn was not eligible for Medicaid from October 1, 2016 through December 31, 2016, because the program [REDACTED] is eligible for cannot pay for any care [REDACTED] received in the past.

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 or not 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.

Since you updated your newborn's completed application on January 3, 2017, your request for retroactive Medicaid for the months of October 2016 through December 2016 should have been considered.

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 through January 31, 2017. Since, as discussed above, your newborn was not eligible for Medicaid as of the January 4, 2017 eligibility determination, she would not be eligible for Medicaid as of January 1, 2017. Therefore, this issue is further refined to whether NYSOH properly determined your child to be ineligible for retroactive Medicaid for the months of October 2016, November 2016 and December 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, November 2016, and/or December 2016, your newborn would have needed to meet the non-financial criteria and have an income no greater than 223% of the FPL, which is \$4,516.00 per month. There is no indication in the record that your newborn would have been ineligible for Medicaid based on non-financial criteria during any of those months.

You testified that you are paid bi-weekly. You uploaded paystubs dated October 1, 2016 through December 31, 2016 for a gross pay amount of \$3,953.89, \$5,300.00 and \$5,000.00 in October 2016, November 2016 and December 2016, respectively. Therefore, the record indicates that in the months of November 2016 and December 2016 you had a monthly household income of at least \$5,000.00.

Since your income of at least \$5,000.00 was more than the \$4,516.00 monthly Medicaid limit for November 2016 and December 2016, NYSOH properly determined that your newborn was not eligible for Medicaid coverage during those months.

However, in October 2016, you had a monthly household income of \$3,953.89. Since \$3,953.89 is less than \$4,516.00, you child could have qualified for retroactive Medicaid during that month.

Therefore, the January 4, 2017 eligibility determination is AFFIRMED in part, insofar as it states that your newborn was not eligible for Medicaid in the months of November 2016 and December 2016 and RESCINDED in part, insofar as it states that your newborn was not eligible for Medicaid in the month of October 2016.

Your case is RETURNED to NYSOH to redetermine your newborn's eligibility for retroactive Medicaid coverage for October 2016, based on a four-person household, utilizing 223% of the 2016 FPL for a newborn and a household income of \$3,953.89 for October 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).

Decision

The January 4, 2017 eligibility determination notice stating that your newborn is eligible for Child Health Plus, effective February 1, 2017, is AFFIRMED.

The January 4, 2017 plan enrollment notice is AFFIRMED.

The January 4, 2017 eligibility determination notice pertaining to retroactive Medicaid is AFFIRMED in part, insofar as it states that your newborn was not eligible for retroactive Medicaid in the months of November 2016 and December 2016 and RESCINDED in part, insofar as it states that your newborn was not eligible for retroactive Medicaid in the month of October 2016.

Your case is RETURNED to NYSOH to redetermine your newborn's eligibility for retroactive Medicaid coverage for October 2016, based on a four-person household, utilizing 223% of the FPL for a newborn and a household income of \$3,953.89 for October 2016.

Effective Date of this Decision: July 21, 2017

How this Decision Affects Your Eligibility

Your newborn is eligible for CHP as of February 1, 2017.

Your newborn is not eligible for Medicaid from November 1, 2016 through January 31, 2017.

This is not a final determination of your newborn's eligibility for financial assistance in October 2016. Your case is being sent back to NYSOH to redetermine your newborn's eligibility for retroactive Medicaid coverage for October 2016, based on a four-person household, utilizing 223% of the FPL for a newborn and a household income of \$3,953.89 for October 2016.

This Decision does not affect your newborn's current eligibility.

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

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).

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

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).

The January 4, 2017 eligibility determination notice stating that your newborn is eligible for Child Health Plus, effective February 1, 2017, is AFFIRMED.

The January 4, 2017 plan enrollment notice is AFFIRMED.

The January 4, 2017 eligibility determination notice pertaining to retroactive Medicaid is AFFIRMED in part, insofar as it states that your newborn was not eligible for retroactive Medicaid in the months of November 2016 and December 2016 and RESCINDED in part, insofar as it states that your newborn was not eligible for retroactive Medicaid in the month of October 2016.

Your case is RETURNED to NYSOH to redetermine your newborn's eligibility for retroactive Medicaid coverage for October 2016, based on a four-person household, utilizing 223% of the FPL for a newborn and a household income of \$3,953.89 for October 2016.

Your newborn is eligible for CHP as of February 1, 2017.

Your newborn is not eligible for Medicaid from November 1, 2016 through January 31, 2017.

This is not a final determination of your newborn's eligibility for financial assistance in October 2016. Your case is being sent back to NYSOH to redetermine your newborn's eligibility for retroactive Medicaid coverage for October 2016, based on a four-person household, utilizing 223% of the FPL for a newborn and a household income of \$3,953.89 for October 2016.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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।

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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye b etumi ama wo obi a okyer e 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 کرم 1-855-355-5777 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.