



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

Notice of Decision

Decision Date: August 29, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000017326

[REDACTED]

Dear [REDACTED],

On July 12, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's determination that you were not eligible for full Medicaid coverage for the months of October 2016 and November 2016.

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: August 29, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000017326

[REDACTED]

Issue

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

Did NY State of Health (NYSOH) properly determine that you were not eligible for full Medicaid coverage for the months of October 2016 and November 2016?

Procedural History

On August 15, 2016, you submitted an updated application for financial assistance.

In a notice issued on August 16, 2016, you were determined conditionally eligible for Medicaid, effective August 1, 2016. The notice directed you to provide proof of income by August 30, 2016.

On August 18, 2016, you uploaded income documentation to your NYSOH account.

On August 24, 2016, you uploaded income documentation to your NYSOH account.

On August 25, 2016, NYSOH issued a notice stating that the documentation you provided did not confirm the income in your application. The notice directed you to provide proof of income by September 14, 2016.

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On August 30, 2016, NYSOH issued a notice stating that the documentation you provided did not confirm the income in your application. The notice directed you to provide proof of income by September 14, 2016.

On September 1, 2016, NYSOH issued a notice of eligibility determination stating that you remained conditionally eligible for Medicaid, effective August 1, 2016. The notice directed you to provide proof of income by September 14, 2016.

On September 14, 2016, you uploaded income documentation to your NYSOH account.

On September 21, 2016, NYSOH issued a notice of issued a notice stating that the documentation you provided did not confirm the income in your application. The notice directed you to provide proof of income by October 14, 2016.

On September 29, 2016, you uploaded income documentation to your NYSOH account.

On October 12, 2016, NYSOH issued a notice stating that the documentation you provided did not confirm the income in your application. The notice directed you to provide proof of income by October 29, 2016.

On October 21, 2016, you updated your NYSOH application.

On October 22, 2016, NYSOH issued an eligibility determination stating that you were conditionally eligible for Medicaid, effective October 1, 2016. The notice directed you to provide proof of income by November 5, 2016.

Also, on October 22, 2016, you uploaded income documentation to your NYSOH account.

Also on October 22, 2016, NYSOH issued a notice stating that the information in your October 21, 2016 application did not match what NYSOH received from state and federal sources. The notice directed you to provide proof of current income by November 5, 2016.

On October 24, 2016 and October 25, 2016, you uploaded income documentation to your NYSOH account.

Your child was born on [REDACTED].

On November 2, 2016, NYSOH verified your income documentation.

On November 3, 2016 NYSOH redetermined your eligibility.

On November 4, 2016, NYSOH issued a notice of eligibility redetermination stating that you remained conditionally eligible for Medicaid, effective

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November 1, 2016. The notice directed you to provide proof of current income by November 20, 2016.

Also on November 4, 2016, NYSOH issued a notice stating that the information in your October 21 2016 application did not match what NYSOH received from state and federal sources. The notice directed you to provide proof of current income by November 20, 2016.

On November 7, 2016, you uploaded income documentation to your NYSOH account.

On November 15, 2016, you updated your NYSOH application, and requested retroactive coverage.

On November 16, 2016, NYSOH issued a notice stating that the information in your November 15, 2016 application did not match what NYSOH received from state and federal sources. The notice directed you to provide proof of current income by November 20, 2016.

On November 18, 2016 and November 19, 2016, you uploaded income documentation to your NYSOH account.

On November 29, 2016, NYSOH verified your income documentation.

On November 30, 2016, NYSOH issued a notice of eligibility redetermination stating that you were eligible for full Medicaid, effective December 1, 2016.

On December 1, 2016, you selected a Medicaid Managed Care plan.

On December 2, 2016, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in a Medicaid Managed Care plan, effective January 1, 2017.

On March 27, 2017, you spoke to NYSOH's Account Review Unit and appealed the fact that you were not found eligible for full Medicaid benefits for the period of October 2016 and November 2016.

On July 12, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

- 1) According to your NYSOH account you were found conditionally eligible for Medicaid as of August 1, 2016 and again on November 1, 2016 pending submission of household income documentation.
- 2) According to your NYSOH account, you first provided income documentation on August 18, 2016. On that date, you uploaded one biweekly pay stub from your employer with a pay date of July 22, 2016 and a gross pay amount of \$608.00.
- 3) NYSOH records reflect that on August 24, 2016, NYSOH deemed this proof of income invalid as you submitted only one biweekly pay stub and your spouse did not provide proof of income.
- 4) Also on August 24, 2016, you uploaded income documentation to your NYSOH account including:
 - a. A biweekly pay stub from your employer [REDACTED] with a pay date of July 22, 2016 and a gross pay amount of \$608.00.
 - b. A biweekly pay stub from your employer [REDACTED] with a pay date of August 19, 2016 and a gross pay amount of \$991.00.
- 5) NYSOH records dated September 2, 2016 reflect that NYSOH deemed your four weeks of pay stubs as valid proof of income. However, NYSOH records reflect that your spouse attested to income from an employer but you did not submit proof of his income.
- 6) On September 14, 2016, you uploaded income documentation to your NYSOH account including:
 - a. A weekly pay stub from your spouse's employer, [REDACTED] [REDACTED] with a pay date of July 31, 2016.
 - b. A weekly pay stub from [REDACTED] with a pay date of September 16, 2016.
 - c. Two pay stubs from [REDACTED] which are illegible.
- 7) NYSOH records reflect that on September 20, 2016, NYSOH determined the proof of income for your spouse were determined invalid because only one weekly pay stub was valid, one was outdated, and the other pay stubs were illegible.
- 8) On October 22, 2016, you uploaded four consecutive pay stubs from your spouse's employer.

- 9) On October 25, 2016, you uploaded a letter dated October 25, 2016 from your employer stating that you were taken out of work by [REDACTED] as of September 23, 2016 and that you have not worked since.
- 10) You child was born on [REDACTED].
- 11) You testified that you [REDACTED] did not have any income in October 2016 and November 2016.
- 12) On November 2, 2016, NYSOH verified your income documentation.
- 13) On November 4, 2016, NYSOH requested proof of current income.
- 14) On November 7, 2016 and November 18, 2016, you uploaded income documentation to your NYSOH account including the following:
 - a. A weekly paystub from your spouse's employer, [REDACTED] with a pay date of October 28, 2016 in the amount of \$468.00.
 - b. A weekly paystub from your spouse's employer, [REDACTED] with a pay date of November 4, 2016 in the amount of \$192.00.
 - c. A letter dated November 18, 2016 from your spouse's employer, [REDACTED] stating that your spouse did not work the week of pay period November 11, 2016 and had no income for that week.
 - d. A weekly paystub from your spouse's employer, [REDACTED] with a pay date of November 18, 2016 in the amount of \$456.00.
- 15) On November 29, 2016, NYSOH verified your income documentation determining your monthly household income to be \$1,116.00.
- 16) On November 30, 2016, NYSOH issued a notice of eligibility redetermination stating that you were eligible for full Medicaid, effective December 1, 2016.
- 17) According to your NYSOH account, you had presumptive Medicaid from August 2016 through November 2016.
- 18) Information entered into the notes for Incident [REDACTED] by a NYSOH Account Review Unit representative on March 27, 2017 indicate that you informed NYSOH that your appeal was requesting full Medicaid eligibility for yourself for the period of October 2016 and November 2016 as opposed to the to the presumptive eligibility that you had been given.

- 19) The request for full Medicaid benefits for you for the period of October 2016 and November 2016 was not granted and an appeal request was processed by NYSOH on this issue.
- 20) You testified that you were seeking full Medicaid eligibility for October 2016 and November 2016 because you have medical bills from that month which were not covered by the presumptive eligibility you were given.
- 21) You testified that the Medicaid coverage that you had did not cover certain hospital charges from October 2016 and November 2016 related to the birth of your child on [REDACTED], and you want to appeal those charges not being covered.
- 22) You testified that you submitted the income documentation requested of you to show that you were eligible for Medicaid in the months of October 2016 and November 2016 [REDACTED].
- 23) There is no indication that NYSOH responded to your November 2016 request for retroactive Medicaid coverage.

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

Applicable Law and Regulations

De Novo Review

NYSOH's Appeals Unit must review each appeal de novo and "consider all relevant facts and evidence adduced during the appeals process" (45 CFR § 155.535(f)). "De novo review means a review of an appeal without deference to prior decisions in the case" (45 CFR § 155.500).

Household Composition

For purposes of Medicaid eligibility, the household size of either a pregnant woman or a per child who is in the family of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

Medicaid for Pregnant Women

Medicaid can be provided through the Marketplace 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

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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 federal poverty level (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 New York, a pregnant woman is eligible for Medicaid at a household income of 223% of the FPL for the applicable family size (42 CFR §435.116 (c)(2); NY Department of Social Services Administrative Directive 13ADM-03).

“Family size” means the number of persons counted as members of an individual’s household. The household of a taxpayer who expects to file a tax return, and does not expect to be claimed as a tax dependent by anyone else, consists of the taxpayer plus all people the taxpayer expects to claim as tax dependents (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 August 15, 2016 application, that was the 2016 FPL, which is \$20,160.00 for a three-person household (81 Federal Register 4036).

Generally, Medicaid coverage begins on the first day of the month in which the applicant was found eligible (42 CFR § 435.915(b)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were not eligible for full Medicaid coverage for the months of October 2016 and November 2016.

The record reflects that on August 15, 2016 you updated your application for financial assistance, and stated you were [REDACTED]. On August 16, 2016, you were determined conditionally eligible for Medicaid, effective August 1, 2016. The notice directed you to provide proof of income by August 30, 2016.

On August 18, 2016, you uploaded income documentation to your NYSOH account. However, on August 20, 2016, NYSOH issued a notice stating that the documentation you provided did not confirm the income in your application; you only provided one biweekly pay stub and your spouse did not provide proof of income. The notice directed you to provide proof of income by September 14, 2016.

On August 24, 2016, you uploaded four consecutive pay stubs from your employer which were verified; however you did not submit proof of your spouse's income. You were directed to provide proof of your spouse's income.

On September 14, 2016, you submitted four pay stubs on behalf of your spouse. However, NYSOH records reflect that on September 20, 2016, NYSOH determined the proof of income for your spouse was invalid because only one weekly pay stub was valid, one was outdated, and the other two pay stubs were illegible.

Since NYSOH did not receive the required documentation, your eligibility remained conditional.

On October 22, 2016, you uploaded four consecutive pay stubs from your spouse's employer. On October 25, 2016, you uploaded a letter dated October 25, 2016 from your employer stating that you were taken out of work [REDACTED] as of September 23, 2016 for [REDACTED].

On November 2, 2016, NYSOH verified your income documentation.

On November 4, 2016, NYSOH stating that you remained conditionally eligible for Medicaid, effective November 1, 2016. The notice directed you to provide proof of current income by November 20, 2016.

On November 7, 2016, November 18, 2016 and November 19, 2016, you uploaded income documentation to your NYSOH account.

On November 29, 2016, NYSOH verified your income documentation.

On November 30, 2016, NYSOH issued a notice of eligibility redetermination stating that you were eligible for full Medicaid, effective December 1, 2016.

However, the record contains no indication that NYSOH issued any notice that addresses your request to be found eligible for retroactive Medicaid coverage for the period from October 1, 2016 through November 1, 2016. The record does contain evidence that on March 27, 2017 you informed NYSOH that your appeal was requesting full Medicaid eligibility for yourself for the period of October 2016 and November 2016 as opposed to the to the presumptive eligibility that you had been given.

Here, the lack of a notice of eligibility determination on the issue of full Medicaid for you for the months of October 2016 and November 2016 does not prevent the Appeals Unit from reaching the merits of the case. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH's failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination. The record of the telephone call made by you to NYSOH on March 27, 2017, in which you stated you wanted to be eligible for full Medicaid as opposed to

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presumptive, permits an inference that NYSOH did deny your request for full Medicaid for you in the months of October 2016 and November 2016.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to an eligibility determination had it been issued. Therefore, the issue under review is whether you were properly denied full Medicaid benefits for the months of October 2016 and November 2016.

According to your NYSOH account and your testimony, you expect to file your 2017 taxes with a tax filing status of married filing jointly and to claim one dependent on that tax return. In October 2016, you were pregnant with one child. For Medicaid purposes, the household of a pregnant woman includes not only the pregnant woman, but also the number of children she is expected to deliver. Since you were pregnant in October 2016 with one child, and resided with your spouse, your household size, for purposes of this analysis, was a three-person household.

Your NYSOH account reflects that you had presumptive Medicaid from August 2016 through November 2016. You testified that your child was born on [REDACTED] and that you were not released from the hospital until [REDACTED]. You testified that you are seeking to have your Medicaid coverage changed to "full" Medicaid coverage for October 2016 and November 2016 when [REDACTED] so that [REDACTED] charges related to your child's birth can be covered.

You were found conditionally eligible for Medicaid in notices dated August 16, 2016, September 1, 2016, and November 4, 2016. Since valid income documentation was not received by NYSOH following those eligibility determinations, your coverage remained presumptive. However, thereafter you uploaded income documentation to your NYSOH account showing that you had an annual household income \$13,392.00. NYSOH validated this income documentation, and used it to grant you Medicaid effective December 1, 2016.

To be eligible for full Medicaid for the months of October 2016 and November 2016, you would have needed to meet the non-financial criteria and have an income no greater than 223% of the 2016 FPL, which is \$3,747.00 per month for a three-person household. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during the months of October 2016 and November 2016. Therefore, the analysis turns to the financial requirements of Medicaid.

NYSOH records reflect that on November 18, 2016, you uploaded a letter from your employer stating that you were taken out of work [REDACTED] as of September 23, 2016 and that you have not worked since. NYSOH accepted this documentation as valid proof of your having \$0.00 income for the months of

October 2016 and November 2016, and used it to determine your eligibility for full Medicaid. Therefore, this analysis is based on this income documentation.

On November 7, 2016 and November 18, 2016, you uploaded income documentation and pay stubs to your NYSOH account for your spouse. On November 29, 2016, NYSOH verified your income documentation determining your monthly household income to be \$1,116.00. This monthly income of \$1,116.00 can be used to determine your eligibility for full Medicaid for the months of September 2016 and November 2016, since NYSOH has already used your spouse's income to determine your eligibility for full Medicaid for December 2016.

According to your NYSOH account, you were still conditionally eligible for Medicaid in October 2016 and November 2016, therefore, your medical expenses for certain labor and delivery charges were not covered by Medicaid. However, the Department of Health will change the presumptive Medicaid eligibility to full Medicaid eligibility, provided documentary evidence supports such a determination. Since NYSOH found you eligible for full Medicaid for December 2016, you are eligible for full Medicaid retroactively for October 2016 and November 2016.

Since the record now contains a more accurate representation of what your household income was, and since NYSOH has accepted your income documentation, your case is RETURNED to NYSOH to consider your request to change your Medicaid eligibility from presumptive eligibility to full coverage, beginning October 1, 2016, and through November 30, 2016. This determination should be based on a three-person household, utilizing 223% of the 2016 FPL for a pregnant woman, and a monthly household income of \$1,116.00, and to notify you accordingly.

Decision

Your case is RETURNED to NYSOH to consider changing your Medicaid eligibility from presumptive eligibility to "full" coverage Medicaid, beginning October 1, 2016, and through November 30, 2016, based on a three-person household, utilizing 223% of the 2016 monthly FPL for a pregnant woman, and a monthly household income of \$1,116.00.

Effective Date of this Decision: August 29, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility for financial assistance.

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

Your case is RETURNED to NYSOH to consider changing your Medicaid eligibility from presumptive eligibility to “full” coverage Medicaid, beginning October 1, 2016, and through November 30, 2016, based on a three-person household, utilizing 223% of the 2016 monthly FPL for a pregnant woman, and a monthly household income of \$1,116.00.

NYSOH will notify you promptly of its redetermination.

If You Disagree with this Decision (Appeal Rights)

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

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

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

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

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:
Health Insurance Marketplace
Attn: Appeals
465 Industrial Blvd.
London, KY 40750-0061
- By fax: 1-877-369-0129

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

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

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

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- 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 consider changing your Medicaid eligibility from presumptive eligibility to “full” coverage Medicaid, beginning October 1, 2016, and through November 30, 2016, based on a three-person household, utilizing 223% of the 2016 monthly FPL for a pregnant woman, and a monthly household income of \$1,116.00.

NYSOH will notify you promptly of its redetermination.

This is not a final determination of your eligibility for financial assistance.

Legal Authority

We are issuing this determination in accordance with 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 مجاناً.

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।

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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&btumi ama wo obi a okyerE kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ 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)

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