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

Notice of Decision

Decision Date: September 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018317
AP000000019603

[redacted]

Dear [redacted],

On August 23, 2017, you appeared by telephone at a hearing on your appeals of NY State of Health's September 18, 2016 and March 23, 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: September 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018317
AP000000019603

[redacted]

Issues

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

> Was your appeal of NY State of Health's (NYSOH) September 18, 2016 eligibility determination notice timely?
>
> Did NYSOH properly determine you and your spouse were eligible to receive up to $438.00 per month in advance payments of the premium tax credit (APTC), effective May 1, 2017?
>
> Did NYSOH properly determine that you and your spouse were not eligible for cost-sharing reductions?
>
> Did NYSOH properly determine that you and your spouse were not eligible for the Essential Plan?
>
> Did NYSOH properly determine that you and your spouse were not eligible for Medicaid?

Procedural History

On January 31, 2016, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible for the Essential Plan for a limited time, effective March 1, 2016. You were directed to produce income documentation by April 29, 2016.

Also on January 31, 2016, NYSOH issued an enrollment confirmation notice stating that you and your spouse were enrolled in the Essential Plan, effective March 1, 2016.

On September 18, 2016, NYSOH issued an eligibility determination notice, stating that you and your spouse were eligible to purchase a qualified health plan at full cost, effective November 1, 2016. The notice stated that you were no longer eligible for the Essential Plan because NYSOH did not receive the income documentation needed to verify your income.

Also on September 18, 2016, NYSOH issued a disenrollment notice, stating that your and your spouse's Essential Plan coverage would end effective October 31, 2016.

On December 14, 2016, you submitted an application for financial assistance with health insurance.

On December 15, 2016, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to enroll in the Essential Plan for a limited time, effective January 1, 2017. You were asked to provide proof of your household income by March 14, 2017.

Also on December 15, 2016, NYSOH issued an enrollment confirmation notice stating that you and your spouse were enrolled in an Essential Plan effective January 1, 2017.

On March 21, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to purchase a qualified health plan at full cost, effective May 1, 2017. You were not eligible for the Essential Plan because NYSOH did not receive the income documentation needed to verify the income listed in your application.

Also on March 21, 2017, NYSOH issued a disenrollment notice stating that your and your spouse's enrollment in an Essential Plan would send effective April 30, 2017 because you were no longer eligible to enroll.

On March 22, 2017, you submitted an application for financial assistance with health insurance.

On March 23, 2017, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible to receive up to $438.00 in APTC, effective May 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.

On April 24, 2017, you spoke to NYSOH's Account Review Unit and appealed the March 23, 2017 eligibility determination, insofar as you were seeking additional financial assistance as of May 1, 2017 [redacted]).

On April 27, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible for the Essential Plan, effective May 1, 2017, because you were granted aid to continue until a decision is made on your appeal.

Also on April 27, 2017, NYSOH issued an enrollment confirmation notice, stating that you and your spouse were enrolled in the Essential Plan, effective May 1, 2017.

On June 7, 2017, you spoke to NYSOH's Account Review Unit and filed an appeal, insofar as you were disenrolled from your Essential Plan in November and December 2016 ([redacted].

On August 23, 2017, you had a telephone hearing for both appeals [redacted]) with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, you stated that you were seeking a redetermination of your and your spouse's eligibility for financial assistance as of May 1, 2017, as well as the reinstatement of your and your spouse's financial assistance for November 2016. The Hearing Officer amended [redacted] to address your and your spouse's financial assistance in November 2016. The record was developed during the hearing and held open up to September 6, 2017, to allow you to submit supporting documents.

On September 4, 2017, you uploaded documentation to your NYSOH account and it was entered into the record as Appellant's Exhibit #1. The record was 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 taxes with a tax filing status of married filing jointly. You will claim one dependent on that tax return.

2) On December 12, 2016, you contacted NYSOH to change the way you receive notices from email to regular mail because you were not receiving electronic alerts.

3) On February 6, 2017, you contacted NYSOH and requested an updated 1095B form because the form you received showed that you did not have coverage in November and December 2016. The notes in the complaint

state that you were informed the letter sent on 9/18/2017 shows a disenrollment as of 10/31/2016.

4) The record reflects that a formal appeal was filed regarding your and your spouse's enrollment in November 2016 on June 7, 2017.

5) The application that was submitted on March 22, 2017 listed annual household income of $59,600.00, consisting of $30,396.00 you earn from your employment and $29,204.00 your spouse earns from his employment. You testified that your income is hard to estimate because you and your spouse are self-employed, but that you expect your spouse to earn less.

6) You provided your and your spouse's 2016 1040 form, which states that your household's adjusted gross income for 2016 was $58,163.00.

7) You provided documentation that your monthly income breakdown for your and your spouse's self-employment:
    a. in January 2017, your household earned $5,596.86
    b. in February 2017, your household earned $4,893.09
    c. in March 2017, your household earned $6,000.06
    d. in August 2017, your household earned $906.96

8) 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.

9) Your application states that you live in [redacted].

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

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR §155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

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 $20,160.00 for a three-person household (81 Fed. Reg. 4036.).

For annual household income in the range of at least 250% but less than 300% of the 2016 FPL, the expected contribution is between 8.21% and 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 $20,160.00 for a three-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 $20,420.00 for a three-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).

Legal Analysis

The first issue is whether your appeal of NYSOH's September 18, 2016 eligibility determination notice was timely.

On January 31, 2016, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible for the Essential Plan for a limited time, effective March 1, 2016. You were directed to produce income documentation by April 29, 2016.

NYSOH did not receive the requested documentation from you. As a result, on September 18, 2016, NYSOH issued an eligibility determination notice stating that you were no longer eligible for the Essential Plan because NYSOH did not receive the income documentation needed to verify your income. You and your spouse were disenrolled from your Essential Plan effective October 31, 2016.

Individual applicants and enrollees must request a hearing within sixty (60) days of the due date of their notice of eligibility determination by NYSOH. For an appeal to have been valid on the issue of the termination of your and your spouse's Essential Plan for November and December 2016, an appeal should have been filed by November 17, 2016. The record reflects that the first time you contacted NYSOH after the disenrollment was December 12, 2016, because you were not receiving notifications. It would be reasonable to infer that you did not receive the September 18, 2016 notices advising you that your Essential Plan was ending, however the record indicates that on February 6, 2017 you contacted NYSOH and requested an updated 1095B form because the form you received showed that you did not have coverage in November and December 2016. The notes in the complaint state that you were informed of the letter sent on 9/18/2017 shows a disenrollment as of 10/31/2016.

Therefore, you had been informed as of February 6, 2017 that you and your spouse had been disenrolled from coverage as of October 31, 2016. A formal appeal on this matter was not filed until June 7, 2017 which is well outside the 60-day deadline to file an appeal.

Therefore, as there has been no timely appeal of the September 18, 2016 eligibility determination notice, your appeal of the coverage referenced within that eligibility determination notice is DISMISSED.

The second issue is whether NYSOH properly determined that you and your spouse were eligible for an APTC of up to $438.00 per month, effective May 1, 2017.

The application that was submitted on March 22, 2017 listed an annual household income of $59,600.00 and the eligibility determination relied upon that information. You testified that your income is hard to predict because you and your spouse are self-employed. However, your 2016 1040 shows an adjusted gross income of $58,163.00. You testified that you expect to earn less than that, but also testified that the income listed in your application was about correct. Therefore, NYSOH properly relied on an annual household income that you provided of $59,600.00 to determine your and your spouse's eligibility.

You and your spouse are in a three-person household. You expect to file your 2017 income taxes as married filing jointly and will claim one dependent on that tax return.

You reside in [redacted], where the second lowest cost silver plan available for couple through NYSOH costs $912.91 per month.

An annual income of $59,600.00 is 295.63% of the 2016 FPL for a three-person household. At 295.63% of the FPL, the expected contribution to the cost of the health insurance premium is 9.56% of income, or $474.81 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 a couple in your county ($912.91 per month) minus your expected contribution ($474.81 per month), which equals $438.10 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you and your spouse to be eligible for up to $438.00 per month in APTC.

The third issue is whether you and your spouse 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 $59,600.00 is 295.63% of the applicable FPL, NYSOH correctly found you and your spouse to be not eligible for cost sharing reductions.

The fourth issue under review is whether NYSOH properly determined that you and your spouse 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 $20,160.00 for a three-person household. Since an annual household income of $59,600.00 is 295.63% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

The fifth issue is whether NYSOH properly determined that you and your spouse 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 $20,420.00 for a three-person household. Since $59,600.00 is 291.87% of the 2017 FPL, NYSOH properly found you and your spouse to be not eligible for Medicaid on an expected annual income basis, using the information provided in your application.

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 documentation that shows in March 2017, your household earned $6,000.06.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $2,349.00.00 per month. Since the documentation you provided shows that you earned $6,000.06 in March 2017 you and your spouse do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the March 23, 2017 eligibility determination properly stated that, based on the information you provided, you and your spouse were eligible for up to $438.00 per month in APTC, not eligible for cost-sharing reductions, not eligible for the Essential Plan and not eligible for Medicaid, it is correct and is AFFIRMED.

Decision

Your appeal of the September 18, 2016 eligibility determination notice is untimely and is DISMISSED.

The March 23, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: September 26, 2017

How this Decision Affects Your Eligibility

You and your spouse remain eligible for up to $438.00 in APTC.

You and your spouse are not eligible for cost-sharing reductions.

You and your spouse are not eligible for the Essential Plan.

You and your spouse are not eligible for Medicaid.

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 appeal of the September 18, 2016 eligibility determination notice is untimely and is DISMISSED.

The March 23, 2017 eligibility determination notice is AFFIRMED.

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).

You and your spouse remain eligible for up to $438.00 in APTC.

You and your spouse are not eligible for cost-sharing reductions.

You and your spouse are not eligible for the Essential Plan.

You and your spouse are not eligible for Medicaid.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

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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