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

Notice of Decision

Decision Date: September 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020019

[redacted]

Dear [redacted],

On September 20, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 18, 2017 disenrollment notice and June 27, 2017 eligibility determination notice.

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 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020019

[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 Medicaid Managed Care coverage ended effective June 30, 2017?

Did NYSOH properly determine that you were eligible to receive up to $255.00 per month in advance payments of the premium tax credit, effective August 1, 2017?

Did NYSOH properly determine that you were 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 July 26, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective July 1, 2016. You enrolled in a Medicaid Managed Care (MMC) plan shortly thereafter, with such coverage beginning September 1, 2016.

On May 4, 2017, NYSOH issued a notice that it was time to renew your health insurance for the upcoming plan year. That notice stated that, based on

information from federal and state sources, NYSOH could not determine whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by June 15, 2017 or you might lose the financial assistance you were currently receiving.

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

On June 18, 2017, NYSOH issued an eligibility determination notice stating that you are not eligible for Medicaid, Child Health Plus, the Essential plan or to receive tax credits or cost-sharing reductions (CSR) to help pay for the cost of insurance. You also could not enroll in a qualified health plan (QHP) at full cost. 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 July 1, 2017.

On June 18, 2017, NYSOH issued a disenrollment notice stating that your MMC plan coverage would end effective June 30, 2017.

On June 26, 2017, you submitted an application for financial assistance. In response to this application, NYSOH prepared a preliminary eligibility determination stating that you were eligible to receive an advance premium tax credit (APTC) of up to $255.00 and, if you selected a silver-level plan for enrollment, eligible for CSR, effective August 1, 2017.

On June 26, 2017, you spoke to NYSOH's Account Review Unit and appealed that your MMC plan coverage had been terminated as of June 30, 2017, and that you had been found eligible for APTC and CSR, rather than Medicaid because of the June 27, 2017 eligibility determination. You were found eligible for "Aid to Continue" during the pendency of the appeal, so you were reenrolled in the Essential Plan for a limited time.

On June 27, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $255.00 in APTC and, if you selected a silver-level plan for enrollment, eligible for CSR, effective August 1, 2017. That notice also stated that you were not eligible for either the Essential Plan or Medicaid because your income was over the allowable income limits for those programs.

On September 20, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: a letter signed by your employer confirming the total gross income you received during the month of June 2017. The record was to be closed 15 days after the hearing date, or upon the receipt of the above referenced documents, whichever occurred earlier.

On September 21, 2017, you provided the above referenced document to the Appeals Unit through facsimile.

Accordingly, the record was closed on September 21, 2017.

Findings of Fact

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

1) You testified, and the record reflects, that you receive your notices from NYSOH by regular mail.

2) You testified that you did not receive any notices telling you that you needed to update your application in order to renew your MMC coverage.

3) Your NYSOH account reflects that your mailing address had been listed as [redacted] since its inception. You testified that this address was not correct, and the correct address was [redacted]

4) You testified that you were assisted with the initial set-up of your NYSOH account on July 25, 2016 by a certified application counselor or NYSOH representative, who inadvertently provided an incorrect address for mailings from NYSOH to be delivered.

5) Your NYSOH account reflects that your mailing address was updated to its current form on June 26, 2017.

6) You testified that a someone assisted you with creating your account, and this was done over the phone.

7) You testified that you did not know that you needed to update your account until someone from NYSOH contacted you by telephone regarding the status of your coverage.

8) The record reflects that on June 26, 2017 NYSOH received your updated application for health insurance.

9) You testified that a NYSOH representative stated that if you had notified to update your application on a timely basis, you would have been found eligible for Medicaid coverage as of July 1, 2017.

10) You testified that you expect to file your 2017 taxes with a tax filing status of head of household. You will claim one dependent on that tax return.

11) You are seeking insurance for yourself only.

12) The application that was submitted on June 26, 2017 listed annual household income of $34,320.00, consisting of $660.00 per week you earn from your employment with [redacted]. You testified that this amount was correct.

13) You testified, and provided documentation on September 21, 2017, that your monthly income for June 2017 was $2,850.00.

14) Your application states that you will not be taking any deductions on your 2017 tax return.

15) You live in Suffolk County, New York.

16) You testified that you were seeking to be found eligible for Medicaid, rather than for APTC and CSR to purchase a plan through NYSOH, since the plans available through NYSOH are unaffordable to you.

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

Applicable Law and Regulations

Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every twelve months or "whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility" (42 CFR § 435.916(a)(1), (d)). NYSOH must make its "redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency" (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates provided by the individual (45 CFR §155.335(h)).

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 $16,020.00 for a two-person household (81 Federal Register 4036).

For annual household income in the range of at least 200% but less than 250% of the 2016 FPL, the expected contribution is between 6.43% and 8.21% 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 $16,020.00 for a two-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).

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 under review is whether NYSOH properly determined that your MMC plan coverage ended effective June 30, 2017.

You were originally found eligible for Medicaid effective July 1, 2016, and your MMC plan coverage began effective September 1, 2016.

Generally, NYSOH must redetermine a qualified individual's eligibility for Medicaid once every 12 months without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency. NYSOH's May 4, 2017 renewal notice stated that there was not enough information to determine whether you were eligible to continue your financial assistance for health insurance, and that you needed to supply additional information by June 15, 2017, or your financial assistance might end.

Because there was no timely response to this notice, you were terminated from your MMC plan effective June 30, 2017.

You testified that you did not receive any notice from NYSOH telling you that you needed to update the information in your NYSOH account. You testified, and your NYSOH account confirms, that you elected to receive notifications by regular mail. There is no evidence in the record that any of the notices that were sent to your mailing address were returned as undeliverable.

However, you credibly testified that you were assisted with the initial set-up of your NYSOH account on July 25, 2016 by a certified application counselor or NYSOH representative, who inadvertently provided an incorrect address for mailings from NYSOH to be delivered.

Therefore, it is concluded that NYSOH did not give you the required notice to you that you needed to update your account.

The second issue is whether NYSOH properly determined that you were eligible for an APTC of up to $255.00 per month, effective August 1, 2017.

The application that was submitted on June 26, 2017 listed an annual household income of $34,320.00 and the eligibility determination relied upon that information.

For purposes of eligibility for APTC, CSR and the Essential Plan, you are in a two-person household. You expect to file your 2017 income taxes as head of household and will claim your older child as dependent on that tax return. You testified that you currently have an arrangement with your ex-spouse to claim only one child if your annual income exceeds $25,000.00. Your younger child resides with you as well, but is currently claimed as a dependent on his father's tax return.

You reside in Suffolk County, where the second lowest cost silver plan available for an individual through NYSOH costs $453.55 per month.

An annual income of $34,320.00 is 214.23% of the 2016 FPL for a two-person household. At 214.23% of the FPL, the expected contribution to the cost of the health insurance premium is 6.94% of income, or $198.39 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 ($453.55 per month) minus your expected contribution ($198.39 per month), which equals $255.16 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $255.00 per month in APTC.

The second issue is whether you were properly found eligible for CSR.

CSR is available to a person who has a household income no greater than 250% of the FPL. Since a household income of $34,320.00 is 214.23% of the applicable FPL, NYSOH correctly found you to be eligible for CSR.

The third 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 $16,020.00 for a two-person

household. Since an annual household income of $34,320.00 is 214.23% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan.

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

For purposes of eligibility for Medicaid, you are in a three-person household. You currently reside with your two children, even though you do not claim them both on your tax return.

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 $34,320.00 is 168.07% 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.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

On September 21, 2017, you submitted a signed letter from your employer that shows that during June 2017 you received $2,850.00.

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 $2,348.00 per month. Since the documentation you provided shows that you earned $2,850.00 in June 2017, you do not qualify for Medicaid based on monthly income as of the date of your application.

Therefore, the June 18, 2017 disenrollment notice is MODIFIED to state that your MMC plan coverage ended effective July 31, 2017.

Furthermore, the June 27, 2017 eligibility determination notice properly stated that, based on the information you provided, you were found eligible for up to $255.00 per month in APTC, eligible for CSR, not eligible the Essential Plan, and not eligible for Medicaid, it is AFFIRMED.

Your case is RETURNED to NYSOH to (1) reinstate your MMC plan coverage during the month of July 2017, and (2) to assist you in enrolling a plan for which you are eligible.

Decision

The June 18, 2017 disenrollment notice is MODIFIED to state that your MMC plan coverage ended effective July 31, 2017.

The June 27, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to (1) reinstate your MMC plan coverage during the month of July 2017, and (2) to assist you in enrolling a plan for which you are eligible.

Effective Date of this Decision: September 27, 2017

How this Decision Affects Your Eligibility

Your MMC plan coverage is reinstated for the month of July 2017.

You remain eligible for an APTC of up to $255.00 per month and, if you selected a silver-level plan for enrollment, eligible for CSR.

You are not eligible for either the Essential Plan or 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

The June 18, 2017 disenrollment notice is MODIFIED to state that your MMC plan coverage ended effective July 31, 2017.

The June 27, 2017 eligibility determination notice is AFFIRMED.

Your MMC plan coverage is reinstated for the month of July 2017.

You remain eligible for an APTC of up to $255.00 per month and, if you selected a silver-level plan for enrollment, eligible for CSR.

You are not eligible for either the Essential Plan or Medicaid.

Your case is RETURNED to NYSOH to assist you in enrolling a plan for which you are eligible.

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).

Legal Authority

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

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

A Copy of this Decision Has Been Provided To:

[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)

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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