



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

## Notice of Decision

Decision Date: October 23, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000020027

[REDACTED]

Dear [REDACTED],

On September 27, 2017 you appeared by telephone at a hearing on your appeal of NY State of Health's June 9, 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  
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## Decision

Decision Date: October 23, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000020027

[REDACTED]

## Issues

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

Did NY State of Health properly determine that you were eligible for the Essential Plan, effective July 1, 2017?

Did NY State of Health properly determine that your spouse was eligible for Medicaid, effective June 1, 2017?

## Procedural History

On January 26, 2017, you submitted an application for financial assistance for your household.

On January 27, 2017, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you and your spouse were eligible to receive up to \$468.00 per month in advance payments of the premium tax credit (APTC), effective March 1, 2017.

On June 8, 2017, you updated your household's application for financial assistance. Specifically, you updated your household's income and indicated that your spouse was pregnant.

On June 9, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan for a limited time, effective July 1, 2017. This notice also stated that your spouse was eligible for Medicaid, effective June 1, 2017. The notice further stated that you must submit

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documentation of your household's income by September 6, 2017 in order to confirm your eligibility for financial assistance.

On June 27, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you and your spouse were not found eligible for APTC.

On June 29, 2017, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible for APTC for a limited time, effective July 1, 2017. This was because you and your spouse had been granted Aid to Continue until a decision was made on your appeal.

On September 21, 2017, you were scheduled for a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. You requested that day that the hearing be adjourned to a later date.

On September 27, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open for fourteen days to allow you to submit additional income documentation. The Hearing Officer directed you to submit your paystubs for June 2017, your two most recent paystubs, your spouse's last paystub from her employer, and a payment history of your spouse's unemployment benefits.

On October 11, 2017, you uploaded fourteen of your paystubs. These documents were collectively marked as [REDACTED]. Also on October 11, 2017, you uploaded a screenshot of your spouse's unemployment benefits payments. This document was marked as [REDACTED]. The record is now closed.

## **Findings of Fact**

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

- 1) You testified that you and your spouse expect to file your 2017 taxes with a tax filing status of married filing jointly. You testified that you will claim your spouse as a dependent on that return as your spouse is unemployed.
- 2) You are seeking insurance for yourself and your spouse.
- 3) You testified that your spouse is pregnant, she is expecting one child, and she is due in [REDACTED]
- 4) The application that was submitted on June 8, 2017 listed annual household income of \$25,956.68, consisting of \$13,494.72 you earn from your employment, and \$18,531.96 your spouse received in wages, less

\$454.00 in student loan interest deductions, and \$5,616.00 in self-employment health insurance deductions.

- 5) You testified that your annual expected income for 2017 is currently between \$30,000.00 and \$45,000.00. You explained that your only source of income for 2017 is your wages from employment. You testified that you received a raise in March 2017 or April 2017.
- 6) You testified that your spouse lost her job in May 2017. You testified that she began receiving unemployment benefits in July 2017 of \$480.00 per week. You further testified that you were not sure what your spouse's final income from her employer was.
- 7) You testified that you and your spouse will be claiming a deduction of \$454.00 for student loan interest on your 2017 tax return, and that this will be your only deduction on your 2017 return.
- 8) Your application states, and you confirmed, that you live in [REDACTED].
- 9) You uploaded fourteen of your paystubs to your NYSOH account. The first is for pay date July 7, 2017 for pay period June 26, 2017 to July 2, 2017 for a gross pay amount of \$921.00 and year to date gross amount of \$18,614.72; the second is for pay date July 17, 2017 for a gross pay amount of \$511.00; the third is for pay date July 24, 2017 for a gross pay amount of \$1,051.50; the fourth is for pay date July 31, 2017 for a gross pay amount of \$950.00; the fifth is for pay date August 7, 2017 for a gross pay amount of \$1,257.00; the sixth is for pay date August 14, 2017 for a gross pay amount of \$1,202.00; the seventh is for pay date August 21, 2017 for a gross pay amount of \$873.88; the eighth is for pay date August 25, 2017 for a gross pay amount of \$1,006.00; the ninth is for pay date September 5, 2017 for a gross pay amount of \$1,257.04; the tenth is for pay date September 11, 2017 for a gross pay amount of \$840.00; the eleventh is for pay date September 18, 2017 for a gross pay amount of \$1,043.00; the twelfth is for pay date September 25, 2017 for a gross pay amount of \$986.00; the thirteenth is for pay date October 2, 2017 for a gross pay amount of \$420.57; the fourteenth is for pay date October 9, 2017 for pay date September 25, 2017 to October 1, 2017 for a gross pay amount of \$1,319.87 and a gross year to date amount of \$31,332.58.
- 10) You uploaded a screenshot of your spouse's unemployment benefits pay history. This indicates that her claim was effective June 5, 2017, that she receives \$430.00 per week, and that as of October 1, 2017 she has 40 effective days remaining on her unemployment claim. The screenshot you provided only shows her payments for week ending August 13, 2017 to October 1, 2017.

11) You testified that your spouse is a natural born United States citizen.

12) You testified that you are a permanent resident and have held this status for over a year.

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

## **Applicable Law and Regulations**

### Household Size

For purposes of advance premium tax credit (APTC) and cost-sharing reductions (CSR), the household size equals the number of individuals for whom the taxpayer is allowed a deduction under 26 USC § 151 for the taxable year, which typically includes: (1) the taxpayer, (2) his or her spouse, and (3) any claimed dependents (26 USC § 36B(d)(1)).

With regard to the Essential Plan, the household size is determined using the above methodology for individuals who file a tax return. (New York's Basic Health Plan Blueprint, p. 19-20, as approved January 2017; see <https://www.medicaid.gov/basic-health-program/basic-health-program.html>).

"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 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)).

For purposes of Medicaid eligibility, however, the household size of either a pregnant woman or a person 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).

### 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).

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

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).

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).

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 \$16,240.00 for a two-person household (82 Fed. Reg. 8831).

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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).

### 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 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)), N.Y. Soc. Serv. Law § 366(1)(b)).

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

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).

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

### Qualified Immigrants

In NY State, qualified immigrants who were formerly eligible for Medicaid through the state, but not eligible for Medicaid under federal law, were transitioned to the Essential Plan as of January 1, 2016 (New York's Basic Health Plan Blueprint, p. 19, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/basic-health-program.html>). This category of qualified immigrants includes individuals lawfully admitted for permanent residence in the United States who are still in their first five years of permanent residency. (18 NYCRR § 349.3, 8 USC § 1613).

## **Legal Analysis**

The first issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan, effective July 1, 2017.

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According to the record, you expect to file your 2017 tax return as married filing jointly and will claim your spouse as a dependent on that return. You testified that your spouse is pregnant, but she is not due until [REDACTED]. Therefore, for Essential Plan purposes, you are in a two-person household.

The application that was submitted on June 8, 2017 listed an annual household income of \$25,956.68 and the eligibility determination relied upon that information.

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 \$25,956.68 is 162.03% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan, using the information in your application.

The second issue is whether NYSOH properly determined that your spouse was eligible for Medicaid, effective June 1, 2017.

When calculating family size for Medicaid purposes, the household size of either a pregnant woman or a person 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. Therefore, your spouse is part of a three-person household.

Medicaid can be provided through NYSOH to pregnant woman who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 223% 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 \$25,956.68 is 127.11% of the 2017 FPL, NYSOH properly found your spouse to be eligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, you testified that the income listed in your application was not correct because you had failed to account for a raise you received in March 2017 or April 2017 as well as your spouse's unemployment benefits. The record also reflects that the application listed deductions of \$5,616.00 for self-employment health insurance deductions, which you indicated you will not be claiming on your 2017 tax return.

Therefore, your household income at the time of your June 8, 2017 application was \$70,850.31 (your income of \$40,732.35, your spouse's wages of \$18,531.96, your spouse's unemployment of \$12,040.00, less deductions of \$454.00). Since \$70,850.31 is 442.26% of the 2016 FPL for a two-person household, it is greater than the allowable Essential Plan limit. Furthermore,

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since \$70,850.31 is 346.97% of the 2017 FPL for a three-person household, it is greater than the allowable Medicaid limit for a pregnant individual.

Therefore, the June 9, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your and your spouse's eligibility based on a two-person household with a pregnant individual, residing in [REDACTED], with an expected annual income of \$70,850.31.

## **Decision**

The June 9, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your and your spouse's eligibility based on a two-person household with a pregnant individual, residing in [REDACTED], with an expected annual income of \$70,850.31.

**Effective Date of this Decision:** October 23, 2017

## **How this Decision Affects Your Eligibility**

You were incorrectly found eligible for the Essential Plan.

Your spouse was incorrectly found eligible for Medicaid.

Your case is being sent back to NYSOH to redetermine your eligibility based on the information presented during your hearing.

## **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

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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 9, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your and your spouse's eligibility based on a two-person household with a pregnant individual, residing in [REDACTED] with an expected annual income of \$70,850.31.

You were incorrectly found eligible for the Essential Plan.

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 spouse was incorrectly found eligible for Medicaid.

Your case is being sent back to NYSOH to redetermine your eligibility based on the information presented during your hearing.

### **Legal Authority**

We are sending you this notice 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&etumi ama wo obi a okyerε 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)**

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.

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).