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

Notice of Decision

Decision Date: December 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020379

[redacted]

Dear [redacted]

On December 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 11, 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: December 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020379

[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 to receive up to $282.00 per month in advance payments of the premium tax credit, effective August 1, 2017?
>
> Did NY State of Health properly determine that you were eligible for cost-sharing reductions?
>
> Did NY State of Health properly determine that you were not eligible for the Essential Plan?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid?

Procedural History

On August 30, 2016, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective October 1, 2016.

Also on August 30, 2016, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective October 1, 2016.

On, June 3, 2017, NYSOH issued a renewal notice stating that, based on information from federal and state data sources, a decision could not be made

about whether you qualified for financial assistance. The notice directed you to update the information in your account by July 15, 2017.

On July 10, 2017, NYSOH received your updated application for financial assistance. That day a preliminary eligibility determination was prepared finding you eligible for advance payments of the premium tax credit (APTC) of up to $282.00 per month and eligible for cost sharing reductions if you enrolled in a silver level qualified health plan, effective August 1, 2017.

On July 10, 2017, you spoke to NYSOH's Account Review Unit and appealed your eligibility for financial assistance and requested to be redetermined eligible for Medicaid.

On July 11, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for APTC of up to $282.00 per month and eligible for cost sharing reductions if you enrolled in a silver level qualified health plan, effective August 1, 2017.

On July 11, 2017, NYSOH issued a disenrollment notice terminating your coverage with your Medicaid Managed Care plan, effective July 31, 2017.

On July 14, 2017, NYSOH issued a notice stating you were eligible for Medicaid for a limited time because you were granted Aid to Continue until a decision was made on your appeal, effective August 1, 2017.

On July 14, 2017, NYSOH issued a notice confirming your enrollment in a Medicaid Managed Care plan, effective August 1, 2017.

A telephone hearing was scheduled for October 31, 2017. A Hearing Officer contacted you at that time and an adjournment was granted for your appointed appeal representative to receive authorization from [redacted] to proceed with an appeal hearing on your behalf.

Your telephone hearing was rescheduled for November 15, 2017. Your hearing was then adjourned by the NYSOH Appeals Unit due to unavailability of the Hearing Officer for that day.

On December 14, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to December 29, 2017, to allow you to submit supporting documents.

On December 18, 2017, NYSOH's Appeals Unit received a two-page fax which was made part of 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 no dependents on that tax return.

2) You are seeking health insurance for yourself.

3) You were determined eligible for Medicaid, effective October 1, 2016.

4) The application submitted on August 29, 2016 stated for 2016 your annual household income was $18,012.00.

5) The application that was submitted on July 10, 2017, listed annual household income of $33,516.00, consisting of $1,501.00 a month you receive from Social Security Disability payments, and $1,292.00 a month your spouse receives from Social Security Benefits. You testified this was correct.

6) You testified you were certified disabled by the Social Security Administration in March 2016, and are not yet eligible for Medicare.

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

8) Your application states that you live in Orange County, NY.

9) You testified that you have bills, including medical bills, and credit card debt that you think should be deducted from your household income.

10) A letter was provided by your medical provider, dated [redacted], stating you reported financial concerns, (*see* Appellant's Exhibit 1).

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

Applicable Law and Regulations

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 2017 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).

<u>Cost-Sharing Reductions</u>

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).

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 2016 FPL, which is $16,020.00 for a two-person household (81 Fed. Reg. 4036).

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).

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).

Generally, most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. For example, even if income increases above the Medicaid limit allowed for the household size, the insured will remain covered under Medicaid for a 12-month period. This 12-month period is referred to as "continuous coverage" and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (NY Social Services Law § 366(4)(c)).

An individual will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, failing to provide a valid social security number, or having third party health insurance (NY Social Services Law § 366(4)(c)).

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions

attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income.

Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income (26 USC § 262(a)).

Medical expenses and dental expenses may be itemized on a Form 1040 Schedule A; however, these expenses are not used to compute adjusted gross income (26 USC § 213(a); Internal Revenue Service (IRS) Publication 502 (2016)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for APTC of up to $282.00 per month.

The application that was submitted on July 10, 2017, listed an annual household income of $33,516.00 and the eligibility determination relied upon that information.

During the hearing, you testified that the amount you provided in your application was correct. However, you asked that your current expenses, which include medical bills, credit card debts, and other living expenses, be considered when calculating your annual household income.

Since the Internal Revenue Service rules do not allow living expenses, such as some of those you mentioned, to be deducted from the calculation of your adjusted gross income, they cannot be deducted when the NYSOH computes your modified adjusted gross income for APTC purposes. Additionally, Medical expenses and dental expenses may be itemized on a Form 1040 Schedule A; however, these expenses are not used to compute adjusted gross income Therefore, NYSOH correctly determined your household income to be $33,516.00.

You are in a two-person household for purposes of this analysis. This is because you expect to file your 2017 income taxes as married filing jointly and will claim no dependents on that tax return.

You reside in Orange County, where the second lowest cost silver plan available for an individual through NYSOH costs $470.66 per month.

An annual income of $33,516.00 is 209.21% of the 2016 FPL for a two-person household. At 209.21% of the FPL, the expected contribution to the cost of the health insurance premium in 2017 is 6.76% of income, or $188.80 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 ($470.66 per month) minus your expected contribution ($188.80 per month), which equals $281.86 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $282.00 per month in APTC.

The second issue under review is whether you were properly found 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 $33,516.00 is 209.21% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined that you were ineligible 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 $33,516.00 is 209.21% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan.

The fourth issue under review is whether NYSOH properly determined that you were ineligible 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 $16,240.00 for a two-person household. Since $33,516.00 is 206.38% of the 2017 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, you were determined eligible for Medicaid effective October 1, 2016. You submitted on August 29, 2016 an application stating for 2016 your annual household income was $18,012.00. On the date of that application, the relevant FPL was $16,020.00 for a two-person household. Since $18,012.00 is 112.43% of the 2016 FPL, you were correctly determined eligible for Medicaid October 1, 2016.

You updated your application on July 10, 2017 to include the income you will be receiving from your and your wife’s Social Security Disability payments. This update increased your annual household income to $33,516.00, which is above the Medicaid limit.

Under New York State law, once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 138% of the FPL. This provision is called “continuous coverage.” The record contains no facts would lead to a determination that you were ineligible for Medicaid based on non-financial criteria during this time-period.

Credible evidence confirms that you were eligible for Medicaid, effective October 1, 2016, and that even though your estimated annual income increased when you modified your application on July 10, 2017, you remain enrolled in Medicaid for the remainder of your 12-month eligibility period until September 30, 2017.

Therefore, the July 11, 2017 eligibility determination notice is MODIFIED to reflect that, although you were no longer eligible for Medicaid, your Medicaid benefits were to continue until the end of your twelve-month eligibility period.

Your case is RETURNED to NYSOH to ensure you remain enrolled in your Medicaid Managed Care plan until the end of your twelve-month period, September 30, 2017. Since you have Aid to Continue in your Medicaid Managed Care plan, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance using a two-person household with an annual household income of $33,516.00, for an individual residing in Orange County, and to notify you accordingly.

Decision

The July 11, 2017 eligibility determination notice is MODIFIED.

Your case is RETURNED to NYSOH to ensure you remain enrolled in your Medicaid Managed Care plan until the end of your twelve-month period, September 30, 2017.

Your case is also RETURNED to NYSOH to redetermine your eligibility for financial assistance using a two-person household with an annual household income of $33,516.00, for an individual residing in Orange County, and to notify you accordingly.

Effective Date of this Decision: December 26, 2017

How this Decision Affects Your Eligibility

You were eligible for APTC up to $282.00 per month as of August 1, 2017.

You were eligible for cost-sharing reductions.

You were ineligible for the Essential Plan.

You remained eligible for Medicaid under continuous coverage until September 30, 2017.

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance using the information noted above. NYSOH will notify you once this has been done.

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 July 11, 2017 eligibility determination notice is MODIFIED.

Your case is RETURNED to NYSOH to ensure you remain enrolled in your Medicaid Managed Care plan until the end of your twelve-month period, September 30, 2017.

Your case is also RETURNED to NYSOH to redetermine your eligibility for financial assistance using a two-person household with an annual household income of $33,516.00, for an individual residing in Orange County, and to notify you accordingly.

You were eligible for APTC up to $282.00 per month as of August 1, 2017.

You were eligible for cost-sharing reductions.

You were ineligible for the Essential Plan.

You remained eligible for Medicaid under continuous coverage until September 30, 2017.

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance using the information noted above. NYSOH will notify you once this has been done.

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)

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।

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).

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 नि:शुल्क 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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