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

Notice of Decision

Decision Date: November 9, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020388

On October 11, 2017, you and your authorized representatives appeared by telephone at a hearing on your appeal of NY State of Health's June 16, 2017 eligibility determination and Retroactive Medicaid 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.

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 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: November 9, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000020388

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 $266.00 per month in advance payments of the premium tax credit, effective July 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?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid from April 1, 2016 through June 30, 2016?

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).

Procedural History

On July 16, 2016, NY State of Health (NYSOH) issued an eligibility determination notice stating that you were eligible for Medicaid, effective July 1, 2016.

Also on July 16, 2016, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective August 1, 2016.

On May 5, 2017, NYSOH issued a renewal notice informing you that it was time for you to renew your health care coverage through NYSOH. This notice stated that you that based on information from state and federal data sources, NYSOH was unable to determine if you qualify for financial help paying for your health coverage, and you must update your NYSOH account between May 16, 2017 and June 15, 2017 to renew your health insurance coverage.

On June 15, 2017, NYSOH received your updated application for financial assistance with health insurance and requested help in paying for medical bills from April 1, 2016 to June 30, 2016.

On June 16, 2017, NYSOH issued a disenrollment notice stating that your coverage in your MMC plan would end June 30, 2017.

Also on June 16, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to $266.00 per month in advanced premium tax credits (APTC) and eligible to receive cost-sharing reductions if you enrolled into a silver-level qualified health plan, effective July 1, 2017. This notice also states that you were not eligible for the Essential Plan or Medicaid because your income was over the allowable income limits for those programs.

On June 16, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a qualified health plan with the application of your advanced premium tax credits, both effective July 1, 2017.

Also on June 16, 2017, NYSOH issued a notice regarding retroactive Medicaid, which stated that NYSOH denied your request for help paying medical bills for April 1, 2016 through June 30, 2016, because the program you are eligible for cannot pay for any care you received in the past.

On July 10, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you were not found eligible for Medicaid or the Essential Plan, and were denied retroactive Medicaid coverage for the months of April 2016 through June 2016.

On July 14, 2017, NYSOH issued an eligibility determination stating that you were eligible for Medicaid through NYSOH, for a limited time, effective July 1,

2017. This notice further stated that you have been granted Aid to Continue until a decision is made on your appeal.

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

On October 11, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Your authorized representatives, [redacted] [redacted] assisted you with your testimony during the hearing. The record was developed during the hearing and held open until October 26, 2017, to allow you to submit supporting documents.

On October 26, 2017, NYSOH's Appeals Unit received a fifteen-page document from you, but only the coverage page and only the first page was legible in this fax.

On November 3, 2017, NYSOH's Appeals Unit received a four-page document from you. All paged were legible, and this document was made part of the record as “Appellant's Exhibit #1”. The record was closed that same 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 single. You will claim no dependents on that tax return.

2) The application that was submitted on June 15, 2017 listed an annual household income of $24,048.00, consisting of the income you receive from [redacted]. You testified that this amount was correct.

3) You testified, and provided documentation to show, that your monthly income for June 2017 was $2,004.00.

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

5) Your application states that you live in [redacted]

6) You testified that you had surgery in September 2015, and you were unable to returned to work.

7) You testified, and submitted documentation to show, that you were terminated from your employment as of October 3, 2016.

8) You testified that you did not start receiving [redacted] November 2016.

9) You testified that you did not have any income for the months of April 2016, May 2016 and June 2016.

10) Your authorized representative testified that you were unsure as to what you were doing when you submitted an application on June 15, 2017, and that the eligibility determination was made in error.

11) You testified that you are seeking to be found eligible for Medicaid or the Essential Plan.

12) You testified that you are seeking retroactive Medicaid coverage for the months of April 2016, May 2016 and June 2016.

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 $11,880.00 for a one-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 for 2017 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 $11,880.00 for a one-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)).

<u>Medicaid</u>

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 $12,060.00 for a one -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).

<u>Retroactive Medicaid</u>

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of an initial application if the individual received medical services that would have been covered under Medicaid and the

individual would have been eligible for Medicaid at the time he received the services if he had applied (42 USCA § 1396A(34); 42 CFR § 435.915(a)). The Department of Health may make eligibility effective for fee-for-service Medicaid on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for an APTC of up to $266.00 per month.

You were originally found eligible for Medicaid, effective July 1, 2016. Your authorized representative testified that you were unsure as to what you were doing when you updated your application on June 15, 2017, and as a result your eligibility determination was made in error.

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.

Therefore, you renewed your eligibility when you submitted an updated application on June 15, 2017. This application listed an annual household income of $24,048.00 and the eligibility determination relied upon that information.

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

You reside in Erie County, where the second lowest cost silver plan available for an individual through NYSOH costs $396.98 per month.

An annual income of $24,048.00 is 202.42% of the 2016 FPL for a one-person household. At 202.42% of the FPL, the expected contribution to the cost of the health insurance premium in 2017 is 6.52% of income, or $130.66 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 ($396.98 per month) minus your expected contribution ($130.66 per month), which equals $266.32 per month. Therefore, rounding to the nearest

dollar, NYSOH correctly determined you to be eligible for up to $266.00 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 $24,048.00 is 202.42% 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 $11,880.00 for a one-person household. Since an annual household income of $24,048.00 is 202.42% 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 $12,060.00 for a one-person household. Since $24.048.00 is 199.40% 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, 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 June 2017 you received $2,004.00.

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 $1,387.00 per month. Since the documentation you provided shows that you earned $2,004.00 in June 2017, you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the June 16, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for up to $266.00 per month in

APTC, eligible for cost-sharing reductions, ineligible for the Essential Plan and ineligible for Medicaid, it is correct and is AFFIRMED.

The last issue under review is whether NYSOH properly determined that you were not eligible for Medicaid from April 1, 2016 to June 30, 2016.

You are in a one-person household. You testified that you did not file a federal tax return in 2016, but that you lived by yourself from April 1, 2016 to June 30, 2016.

You submitted your initial application for financial assistance on July 15, 2016, and you were found eligible for Medicaid, effective July 1, 2016.

You submitted an updated application for financial assistance on June 15, 2017, and requested help in paying for medical bills for April 1, 2016 to June 30, 2016. Subsequently, NYSOH issued an eligibility determination stating that your request for help paying medical bills from April 1, 2016 to June 30, 2016 had been denied because the program you are eligible for cannot help pay for any care you received in the past.

When an individual files an initial application for Medicaid, his or her eligibility for retroactive Medicaid depends on the date of application. To this end, it does not matter whether or not that initial application resulted in Medicaid going forward. Instead, an individual, who has filed an initial application for Medicaid through NYSOH, has the right to be evaluated for Medicaid for the three months before the month of his or her application.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's initial application if the individual received medical services that would have been covered under Medicaid and if they would have been eligible for Medicaid in those three months had they applied.

Your authorized representative testified that you are seeking Medicaid from April 1, 2016 to June 30, 2016.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. To be eligible for Medicaid in April 1, 2016 through June 30, 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which was $1,367.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria from April 1, 2016 through June 30, 2016.

You testified that you had surgery in September 2015, and were unable to return to work. As a result, you testified and submitted documentation to show that you were terminated from your employment as of October 3, 2016. You further

testified that you did not receive any income for the months of April 2016 through June 2016, and did not file a 2016 tax return. Therefore, the record indicates that in the months of April 2016 through June 2016, you had no monthly household income and the July 16, 2017 notice of retroactive Medicaid is RESCINDED.

Since the record now contains a more accurate representation of what your income was for the months of April 2016 thought June 2016, your case is RETURNED to NYSOH to consider your request for retroactive coverage from April 1, 2016 through June 30, 2016, based on a household size of one person and a household income of $0.00 for the months of April 2016 through June 2016.

Decision

The June 16, 2017 eligibility determination notice is AFFIRMED.

The June 16, 2017 Notice of Retro Medicaid is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage from April 1, 2016 through June 30, 2016 based on a household size of one person and a household income of $0.00 for the months of April 2016 through June 2016, and to notify you accordingly.

Effective Date of this Decision: November 9, 2017

How this Decision Affects Your Eligibility

NYSOH properly found you eligible for up to $266.00 in APTC, effective July 1, 2017.

NYSOH properly found you eligible for cost-sharing reductions.

NYSOH properly found you ineligible for the Essential Plan.

NYSOH properly found you ineligible for Medicaid.

This is not a final determination of your request for retroactive Medicaid benefits for the months of April 2016 through June 2016. Your case is being sent back to NYSOH to redetermine your eligibility based on the record to date. NYSOH will notify you of the outcome.

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 16, 2017 eligibility determination notice is AFFIRMED.

NYSOH properly found you eligible for up to $266.00 in APTC, effective July 1, 2017.

NYSOH properly found you eligible for cost-sharing reductions.

NYSOH properly found you ineligible for the Essential Plan.

NYSOH properly found you ineligible for Medicaid.

The June 16, 2017 Notice of Retro Medicaid is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage from April 1, 2016 through June 30, 2016 based on a household size of one person and a household income of $0.00 for the months of April 2016 through June 2016, and to notify you accordingly.

This is not a final determination of your request for retroactive Medicaid benefits for the months of April 2016 through June 2016. Your case is being sent back to NYSOH to redetermine your eligibility based on the record to date. NYSOH will notify you of the outcome.

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 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.

(Urdu)اردو

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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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