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

Notice of Decision

Decision Date: November 2, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021021

[redacted]

Dear [redacted],

On October 13, 2017 you appeared by telephone at a hearing on your appeal of NY State of Health's June 30, 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: November 2, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021021

[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 $194.00 per month in advance payments of the premium tax credit, effective August 1, 2017?
>
> Did NY State of Health properly determine that you were ineligible for cost-sharing reductions?
>
> Did NY State of Health properly determine that you were ineligible for the Essential Plan?
>
> Did NY State of Health properly determine that you were ineligible for Medicaid?

Procedural History

On June 2, 2017, you submitted an application for financial assistance and uploaded income documentation to your NYSOH account.

Also on June 2, 2017, NY State of Health (NYSOH) reviewed the income documentation you submitted and determined that this was insufficient to resolve the inconsistency in your application.

On June 3, 2017, NYSOH issued a notice stating that the income information you provided did not match income information NYSOH had received from state and

federal data sources and that additional information was needed in order to determine your eligibility for financial assistance. This notice directed you to submit documentation of your income by June 17, 2017.

On June 3, 2017, NYSOH issued a notice stating that the documentation you submitted did not confirm the information in your application and that additional income documentation was due by June 17, 2017.

On June 14, 2017, you uploaded income documentation to your NYSOH account.

On June 15, 2017, NYSOH reviewed the income documentation you submitted and determined that this was insufficient to resolve the inconsistency in your application.

On June 16, 2017, NYSOH issued a notice stating that the documentation you submitted did not confirm the information in your application and that additional income documentation was due by July 2, 2017.

On June 19, 2017, you uploaded income documentation to your NYSOH account.

Also on June 19, 2017, NYSOH reviewed the income documentation you submitted and determined that this was insufficient to resolve the inconsistency in your application.

On June 20, 2017, NYSOH issued a notice stating that the documentation you submitted did not confirm the information in your application and that additional income documentation was due by July 17, 2017.

On June 21, 2017, you submitted income documentation to your NYSOH account.

Also on June 21, 2017, NYSOH reviewed the income documentation you submitted, recalculated your income based on this documentation, updated the information in your application, and submitted an application on your behalf.

On June 22, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $140.00 per month in advance payments of the premium tax credit (APTC), effective August 1, 2017.

On June 26, 2017, you submitted an application for financial assistance.

On June 27, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $323.00 per month in APTC for a limited time and cost-sharing reductions if you enrolled in a silver level qualified health plan

for a limited time, effective August 1, 2017. This notice directed you to submit documentation of your income by September 24, 2017 in order to confirm your eligibility for financial assistance.

On June 29, 2017, you uploaded income documents to your NYSOH account.

On June 29, 2017, NYSOH reviewed income documents you submitted, recalculated your income based on these documents, updated the income in your application to reflect this recalculated income, and submitted an application on your behalf.

On June 30, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $194.00 in APTC, effective August 1, 2017. That notice also stated that you were not eligible for cost-sharing reductions, the Essential Plan, or Medicaid because your income was over the allowable income limits for those programs.

On July 31, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were not found eligible for Medicaid.

On October 13, 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.

On October 13, 2017, you uploaded two paystubs to your NYSOH account. On October 19, 2017, you uploaded six paystubs to your NYSOH account. These documents are hereby incorporated into the record. The record is now closed.

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 not claim any dependents on that tax return.

2) You are seeking insurance for yourself.

3) On June 2, 2017, you uploaded one paystub from [redacted] to your NYSOH account for pay date May 26, 2017 for a gross pay amount of $765.00.

4) On June 14, 2017, you uploaded four additional paystubs from [redacted] to your NYSOH account; the first is for pay date April 28, 2017 for a gross pay amount of $765.00; the second is for pay date May 19, 2017 for a gross pay amount of $765.00; the third is for pay date June 2, 2017 for a

gross pay amount of $765.00; the fourth is for pay date June 9, 2017 for a gross pay amount of $688.50.

5) On June 19, 2017, you uploaded one additional paystub from [redacted] to your NYSOH account for pay date May 12, 2017 for a gross pay amount of $765.00.

6) On June 21, 2017, you uploaded one additional paystub from [redacted] to your NYSOH account for pay date June 16, 2017 for a gross pay amount of $765.00.

7) The application that was submitted on June 26, 2017 listed annual household income of $24,000.00, consisting of $30,000.00 you earn from your employment at [redacted] less $6,000.00 in business expense deductions.

8) On June 29, 2017, you uploaded your Schedule C Profit or Loss from Business form from your 2016 tax return.

9) On June 29, 2017, NYSOH recalculated your income to be $33,780.00 consisting of $39,780.00 in wages from [redacted] less $6,000.00 in business expense deductions. That day, NYSOH updated your application to reflect this income and submitted an application on your behalf.

10) You testified that in 2017 you have performed [redacted] for [redacted] and [redacted] You explained that you have a regular income from [redacted] and are paid weekly, however, the amount of hours you work is subject to change. You testified that your work for [redacted] is very infrequent and is done on a job by job basis.

11) You testified that you believe your income for 2017 will be between $31,000.00 and $36,000.00. You explained that you believe your job status may change later this year and that you may be let go, however this has not yet happened, and you do not have a date for when this may happen.

12) You testified that you did not receive any pay from [redacted] in June 2017.

13) On October 13, 2017, you uploaded two paystubs from [redacted] to your NYSOH account; the first is for pay date June 23, 2017 for a gross pay amount of $765.00; the second is for pay date June 30, 2017 for a gross pay amount of $765.00.

14) On October 19, 2017, you uploaded five paystubs from [redacted]; the first is for pay date September 15, 2017 for a gross pay amount of $850.00; the second is for pay date September 22, 2017 for a gross pay amount of $850.00; the third is for pay date September 29, 2017 for a gross pay amount of $850.00; the fourth is for pay date October 6, 2017 for a gross pay amount of $850.00; the fifth is for pay date October 13, 2017 for a gross pay amount of $680.00 and a gross year to date amount of $31,050.50.

15) Also on October 19, 2017, you uploaded three paystubs from [redacted] the first is for pay date September 22, 2017 for a gross pay amount of $148.50; the second is for pay date October 6, 2017 for a gross pay amount of $44.00; the third is for pay date October 13, 2017 for a gross pay amount of $80.00 and a gross year to date amount of $660.50.

16) Your application states, and you confirmed, that you will be taking $6,000.00 in business expense deductions on your 2017 tax return.

17) Your application states, and you confirmed, that you live in Suffolk County.

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 250% but less than 300% of the 2016 FPL, the expected contribution is between 8.21% and 9.69% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

People who use the APTC to help pay health insurance premiums must file a federal tax return and reconcile their expected income (stated on NYSOH application) with their actual income (stated on their federal income tax return). Those who take less tax credit in advance than they claim on the tax return may get the rest of it as an income tax refund or have their tax bill reduced. Those who take more tax credit in advance than they can claim on their tax return will owe the difference as additional income taxes (26 CFR § 1.36B-4).

Cost-Sharing Reductions

Cost-sharing reductions (CSR) are available to a person who (1) is eligible to enroll in a QHP through NYSOH, (2) meets the requirements to receive APTC, (3) is expected to have an annual household income that does not exceed 250% of the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level QHP (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully

present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your application, that was the 2016 FPL, which is $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)).

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 $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).

Legal Analysis

The first issue is whether NYSOH properly determined that you were eligible for an APTC of up to $194.00 per month.

You expect to file your 2017 tax return as single and will not claim any dependents on that tax return. Therefore, you are in a one-person household.

On June 29, 2017, NYSOH recalculated your household income to be $33,780.00, consisting of $39,780.00 in wages from [redacted] ($765.00 per week) less $6,000.00 in business expense deductions. The eligibility determination issued on June 30, 2017 relied on this recalculation.

As this income recalculation relied upon the income information you submitted, there is insufficient documentation in the record to disturb the income determination by NYSOH.

You reside in Suffolk County, where the second lowest cost silver plan available for an individual through NYSOH costs $453.37 per month.

An annual income of $33,780.00 is 284.34% of the 2016 FPL for a one-person household. At 284.34% of the FPL, the expected contribution to the cost of the health insurance premium is 9.23% of income, or $259.73 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 ($453.37 per month) minus your expected contribution ($259.73 per month), which equals $193.64 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $194.00 per month in APTC.

The second issue is whether you were properly found ineligible 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 $33,780.00 is 284.34% of the applicable FPL, NYSOH correctly found you to be ineligible 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 $33,780.00 is 284.34% 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 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 $33,780.00 is 280.10% 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 paystubs that show in June 2017 you received $3,748.50.

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 $3,748.00 in July 2017 you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the June 30, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for up to $194.00 per month in APTC, ineligible for cost-sharing reductions, ineligible for the Essential Plan and ineligible for Medicaid, it is correct and is AFFIRMED.

Following the hearing you submitted paystubs that show that your annual expected income is currently $35,224.30, consisting of $40,365.65 from [redacted] (year to date gross of $40,365.65 averaged over 40 weeks worked, multiplied by 52 weeks) and $858.65 from [redacted] ($660.50 averaged over 40 weeks worked, multiplied by 52 weeks) less $6,000.00 in business expense deductions.

Therefore, your case is RETURNED to NYSOH to recalculate your eligibility based on a household of one, residing in Suffolk County, with an annual expected income of $35,224.30.

Decision

The June 30, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your eligibility based on a household of one, residing in Suffolk County, with an annual expected income of $35,224.30.

Effective Date of this Decision: November 2, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH for a redetermination of your eligibility based on the income documentation you submitted following 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 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 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).

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 30, 2017 eligibility determination notice is AFFIRMED.

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH for a redetermination of your eligibility based on the income documentation you submitted following your hearing.

Your case is RETURNED to NYSOH to recalculate your eligibility based on a household of one, residing in Suffolk County, with an annual expected income of $35,224.30.

Legal Authority

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

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.

□□□□□ (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).

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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 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)

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).

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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