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

Notice of Decision

Decision Date: January 11, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022855

[redacted]

[redacted]

On December 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 3, September 4, and September 27, 2017 eligibility determination 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.

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: January 11, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022855

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health (NYSOH) properly determine that you were not eligible for Medicaid assistance for June and August 2017?
>
> Did NYSOH properly determine that your children were not eligible for Medicaid assistance for June and August 2017?

Procedural History

On July 7, 2017, you submitted an updated application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for April, May, and June 2017 on behalf of yourself and your children.

On July 8, 2017, NYSOH issued a notice stating that the income information in your application did not match the information NYSOH received from state and federal data sources. The notice directed you to submit documentation of your household income by July 22, 2017.

On August 2, 2017, NYSOH redetermined your eligibility.

On August 3, 2017, NYSOH issued a notice of eligibility determination stating that you and your children were eligible to purchase a qualified health plan at full cost through NYSOH, effective September 1, 2017. You were not eligible for

financial assistance because NYSOH had not received documentation needed to verify your household income.

Also on August 3, 2017, NYSOH issued a notice stating that your request for Medicaid coverage for April 1, 2017 through June 30, 2017, on behalf of yourself and your two children, was denied because NYSOH did not receive documentation of your household income.

On August 7, 2017, you updated your NYSOH application and uploaded documentation to your NYSOH account. In that application, you indicated that you were seeking help paying for medical bills on behalf of yourself and your children for the month of July 2017.

That same day, NYSOH also reviewed the documentation you submitted and redetermined your eligibility.

On August 8, 2017, NYSOH issued a notice of stating that the income documentation you submitted was not sufficient to confirm the information in your application, and that you needed to provide documentation of your income by August 22, 2017.

On September 3, 2017, NYSOH redetermined your eligibility.

On September 4, 2017, NYSOH issued a notice of eligibility determination stating that you and your children were eligible to purchase a qualified health plan at full cost through NYSOH, effective October 1, 2017. You were not eligible for financial assistance because NYSOH had not received documentation needed to verify your household income.

Also on September 4, 2017, NYSOH issued a notice stating that your request for Medicaid coverage for the month of July 2017 on behalf of yourself and your two children was denied because NYSOH did not receive documentation of your household income.

On September 14, 2017, you updated your NYSOH application and indicated that you were seeking help for paying for medical bills for August 2017 on behalf of yourself and your children.

On September 15, 2017, NYSOH issued a notice stating that the income information in your application did not match the information NYSOH received from state and federal data sources. The notice directed you to submit documentation of your household income by September 29, 2017.

On September 18, 2017, you uploaded documentation to your NYSOH account.

On September 23, 2017, NYSOH issued a notice stating that the income documentation you submitted was not sufficient to confirm the information in your application, and that you needed to provide income documentation by October 14, 2017.

On September 25, 2017, you uploaded additional documentation to your NYSOH account.

That same day, NYSOH redetermined your eligibility.

On September 26, 2017, NYSOH issued a notice stating that the income information in your application did not match the information NYSOH received from state and federal data sources. The notice directed you to submit documentation of your household income by October 14, 2017.

That same day, NYSOH redetermined your eligibility.

On September 27, 2017, NYSOH issued a notice of eligibility determination stating that you and your children were not eligible for Medicaid in the month of August 2017 because your income of $3,121.00 was over the allowable monthly income limit of $2,349.00 (for you) and $2,621.00 (for your children).

Also on September 27, 2017, you spoke with NYSOH's Account Review Unit and appealed, insofar as you and your children were not eligible for Medicaid in the months of June, July, and August 2017.

On December 7, 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 through December 22, 2017, to allow you to submit supporting documents.

On December 20, 2017, the Appeals Unit received a 24-page fax submitted on your behalf. The record is now closed.

Findings of Fact

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

1) You testified that you are seeking Medicaid from June 1, 2017 through August 31, 2017 for yourself and your children.

2) Your NYSOH application reflects that you expect to file your 2017 federal income tax return as head of household, and claim two dependents.

3) Your NYSOH account reflects that your children are [redacted] and [redacted].

4) You first submitted an updated application for financial assistance on May 3, 2017.

5) You testified that you were working with an application counselor who was not very helpful, and caused your application to be delayed for several months.

6) You testified that your application counselor kept providing you with misinformation regarding what income documentation you needed to submit, and initially did not tell you that you needed to submit any income documentation at all.

7) Your NYSOH account reflects that you and your children were found eligible for Medicaid, effective September 1, 2017.

8) You testified that you have unpaid medical bills for your son because he [redacted] in the [redacted] of June 2017.

9) You testified that you were working one job with a company called [redacted]" that ended in May 2017.

10) You testified that you received biweekly severance payments from [redacted] of $635.00 per week for ten weeks, but that you were not sure of the exact dates when you received these payments.

11) You testified that you worked a second part-time job with [redacted] during 2017, and that you are currently working ten hours per week at that job.

12) You testified that you recently began another part-time job, approximately three weeks prior to your hearing, where you work an average of ten hours per week for $10.25 an hour.

13) You testified that you began receiving Unemployment Insurance Benefits (UIB) in September 2017, and that your benefit rate is $435.00 per week, but that you do not receive the full amount because of your other work.

14) On September 25, 2017, you uploaded paystubs from your "[redacted] job, including one paystub dated September 1, 2017 showing no current earnings, and year-to-date income of $5,359.46 (Document [redacted]).

15) After the hearing, you faxed a 24-page document to NYSOH, consisting of the following documentation:

a. A one-page cover letter indicating, in part, that you were unable to locate any of your severance paystubs from "[redacted]," but that you included your severance letter;
b. A copy of a paystub from "[redacted]" dated May 26, 2017 showing no current earnings, and year-to-date earnings of $15,747.08. This paystub also reflected year-to-date severance pay of $2,238.60;
c. A copy of a paystub from "[redacted]" dated May 12, 2017 showing current earnings of $395.05, and year-to-date earnings of $13,499.05;
d. A copy of a page from a "Confidential Separation Agreement" between you and "[redacted]" stating that your employment was being terminated as of May 3, 2017, and that you were to be paid 10 weeks of severance at $658.42 per week, paid on a biweekly basis, from May 4, 2017 through July 12, 2017;
e. A copy of a paystub from [redacted] dated June 9, 2017 showing gross weekly earnings of $260.86;
f. A copy of a weekly paystub from "[redacted]" dated June 16, 2017 for gross weekly earnings of $301.50;
g. A copy of a weekly paystub from "[redacted]" dated June 30, 2017 for gross weekly earnings of $148.21;
h. A copy of a weekly paystub from "[redacted]." dated July 7, 2017 for gross weekly earnings of $0.00;
i. A copy of a weekly paystub from "[redacted]." dated July 14, 2017 for gross weekly earnings of $134.24;
j. A copy of a weekly paystub from [redacted]." dated July 21, 2017 for gross weekly earnings of $243.74;
k. A copy of a weekly paystub from [redacted] dated July 28, 2017 for gross weekly earnings of $286.49;
l. A copy of a weekly paystub from [redacted]." dated August 4, 2017 for gross weekly earnings of $118.20;
m. A copy of a weekly paystub from [redacted] dated August 11, 2017 for gross weekly earnings of $177.19, and year-to-date gross earnings of $5,231.84;
n. A three-page "Official Record of Benefit Payment History" showing that you received your first UIB payment on August 13, 2017 in the amount of $215.00, and that you received two more payments in August 2017 of $430.00 each;
o. Four paystubs from "[redacted]" with November and December 2017 paydates;
p. A November 24, 2017 paystub from [redacted]

These documents are collectively marked and entered into the record as "Appellant's Exhibit One."

16) You testified that you do not plan on taking any deductions on your tax return.

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

Applicable Law and Regulations

Medicaid for Adults between the Ages of 19 and 65

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 federal poverty level (FPL) for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of your application, that was the 2017 FPL, which is $20,420.00 for a three-person household (82 Federal Register 8831).

Medicaid for Children

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the FPL for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

In the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all persons whom such individual expects to claim as a tax dependent (42 CFR § 435.603(f)(1).

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).

Retroactive Medicaid

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 not eligible for Medicaid for June 1, 2017 through August 31, 2017.

You are in a three-person household; you file your taxes with a tax filing status of head of household, and claim two dependents on your tax return.

You applied for financial assistance on July 7, 2017, which requested help in paying for medical bills for June 2017; an application on August 7, 2017, which requested help in paying for medical bills for July 2017; and an application on September 14, 2017 which requested help in payment for medical bills for August 2017.

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 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.

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 June, July, and August 2017, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL for each of those months, which is $2,348.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during June, July, and August 2017.

June 2017

You testified that, in the month of June 2017, your income consisted of earnings from your part-time job at [redacted] and severance that you received from your position with [redacted]. After the hearing, the record was left open so that you could submit documentation of your income for the month of June 2017. You submitted a letter stating that you could not find the paystubs for the severance that you received in June 2017. However, you submitted a page from your separation agreement that stated that you would receive ten weeks of severance at $658.42 per week, for a total of $6,584.20. The agreement further stated that this severance would be paid out in biweekly increments (658.42 X 2 = $1,316.84 per biweekly payment) between the dates of May 4, 2017 and July 12, 2017.

Based on this payment schedule, and without paystubs to confirm the precise payment dates, it must be presumed that you received one payment in May 2017, three payments in June 2017, and one payment in July 2017. Therefore, your income in the month of June 2017 from your [redacted] was $3,950.52 ($1,316.84 times 3 payments).

Additionally, you provided paystubs from your position at [redacted] dated June 9, 2017, June 16, 2017, and June 30, 2017. Since you are paid weekly, you should also have provided paystubs from June 2, 2017 and June 23, 2017, but these paystubs were not submitted. Your total income from [redacted]. in June 2017, based on the paystubs submitted, was at least $710.57.

Therefore, even without a complete record of your earnings from [redacted] in June 2017, your monthly income for that month is at least $4,661.09, which is over the monthly Medicaid income limit of $2,348.00. For this reason, you were not eligible for Medicaid in the month of June 2017.

July 2017

You submitted documentation after the hearing which shows that you earned a total of $664.57 from [redacted]. during the month of July 2017 (See Appellant's Exhibit One). Additionally, based on the severance payment schedule outlined in your separation agreement, it is presumed that you received one biweekly severance payment in July 2017, in the amount of $1,316.84. Therefore, your total monthly income for July 2017 was $1,981.31, which is less than the monthly Medicaid income limit of $2,348.00.

August 2017

You submitted documentation to NYSOH showing that your year-to-date income from [redacted]. was $5,359.46 as of September 1, 2017, and that your current earnings in your paycheck for that date were $0.00 ([redacted]. After the hearing, you submitted two weekly paystubs from [redacted] for August

4, 2017 ($116.20) and August 11, 2017 ($177.19). Though you did not submit paystubs for the weeks of August 18, 2017 or August 25, 2017, your total earnings for the two weeks can be determined by taking the year-to-date earnings in your September 1, 2017 paycheck ($5,359.46) and subtracting your year-to-date earnings in your August 11, 2017 paycheck ($5,231.84), which equals $127.62. Therefore, your total earnings for the month of August 2017 from [redacted] are $421.01.

Additionally, you submitted documentation showing that you began receiving UIB payments in the month of August, and that payments you received in that month totaled $1,075.00 ($430.00 + $430.00 + $215.00). Therefore, your total monthly income for August 2017 was $1,496.01, which is less than the monthly Medicaid income limit of $2,348.00.

The second issue under review is whether NYSOH properly determined that your children were not eligible for Medicaid for the period of June 1, 2017 through August 31, 2017.

To be eligible for Medicaid in June, July, and August 2017, your children would have needed to meet the non-financial criteria and have an income no greater than 154% of the FPL for each of those months, which is $2,621.00 per month. There is no indication in the record that your children would have been ineligible for Medicaid based on non-financial criteria during June, July, and August 2017.

June 2017

As determined above, your monthly household income for the month of June 2017 was $4,661.09. Since this amount is more than the $2,621.00 monthly Medicaid income limit for June 2017, your children were not eligible for Medicaid in that month.

July 2017

As determined above, your monthly household income for the month of July 2017 was $1,981.31. Since this amount is less than the $2,621.00 monthly Medicaid income limit for July 2017, your children were financially eligible for Medicaid in the month of July 2017.

August 2017

As determined above, your monthly household income for the month of August 2017 was $1,496.01. Since this amount is less than the $2,621.00 monthly Medicaid income limit for August 2017, your children were financially eligible for Medicaid in the month of August 2017.

Therefore: In accordance with the findings above:

The August 3, 2017 notice stating that you and your children were not eligible for Medicaid in the months of April through June 2017 because you did not submit income documentation is MODIFIED to state that you and your children were not eligible for Medicaid in the month of June 2017 because your monthly income of $4,661.09 was over the allowable monthly income limits.

Since the record now contains a more accurate representation of what your income was for the month of July 2017, your case is RETURNED to NYSOH to consider your request for retroactive coverage for yourself, and for your children, for the month of July 2017, based on a household size of three people and household income of $1,981.31.

Since the record now contains a more accurate representation of what your income was for the month of August 2017, your case is RETURNED to NYSOH to consider your request for retroactive coverage for yourself and your children for the month of August 2017, based on a household size of three people and a household income of $1,496.01.

Decision

The August 3, 2017 eligibility determination is MODIFIED in part, to state that you and your children were not eligible for Medicaid in the month of June 2017 because your monthly income of $4,661.09 was above the allowable income limits.

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for yourself and your children for July 2017, based on a household size of three and household income of $1,981.31 for the month of July.

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for yourself and your children for August 2017, based on a household size of three and a household income of $1,496.01 for the month of August 2017.

NYSOH is directed to notify you in writing of your eligibility.

Effective Date of this Decision: January 11, 2018

How this Decision Affects Your Eligibility

You and your children are not eligible for Medicaid in the month of June 2017.

This is not a final determination of your household's eligibility for Medicaid in July and August 2017. Your case is being sent back to NYSOH to redetermine you and your children's eligibility for Medicaid in those months based on the evidence in the record.

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 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 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 August 3, 2017 eligibility determination is MODIFIED in part, to state that you and your children were not eligible for Medicaid in the month of June 2017 because your monthly income of $4,661.09 was above the allowable income limits.

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for yourself and your children for July 2017, based on a household size of three and household income of $1,981.31 for the month of July.

Your case is RETURNED to NYSOH to consider your request for retroactive Medicaid coverage for yourself and your children for August 2017, based on a household size of three and a household income of $1,496.01 for the month of August 2017.

NYSOH is directed to notify you in writing of your eligibility.

You and your children are not eligible for Medicaid in the month of June 2017.

This is not a final determination of your household's eligibility for Medicaid in July and August 2017. Your case is being sent back to NYSOH to redetermine you and your children's eligibility for Medicaid in those months based on the evidence in the record.

Legal Authority

We are issuing this determination 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.

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.

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).