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

Notice of Decision

Decision Date: January 9, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023225

[redacted]

On November 30, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 31, 2017 and October 11, 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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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).

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

Decision

Decision Date: January 9, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023225

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly determine that you were not eligible for Medicaid for June 2017?
>
> Did NYSOH properly determine that you were eligible to receive up to $286.00 per month in advance premium tax credits and eligible for cost-sharing reductions, effective November 1, 2017?
>
> Were you eligible for retroactive Medicaid for the months of July 2017, August 2017, and September 2017?

Procedural History

On July 17, 2017, you submitted an application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for April 2017, May 2017 and June 2017.

On July 18, 2017, NYSOH issued a notice stating more information was needed to make a determination. The notice explained the income information in your application did not match what was obtained from state and federal data sources. You were asked to submit income documentation for your household by August 1, 2017.

On August 31, 2017, NYSOH issued an eligibility determination notice stating that you were newly eligible to purchase a qualified health plan at full cost. The

notice stated that you were not eligible for Medicaid because NYSOH did not receive the income documentation needed to verify the income listed in your application. This eligibility was effective October 1, 2017.

Also on August 31, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid for April 2017, May 2017 or June 2017, because NYSOH did not receive the income documentation needed to verify the income listed in your application.

On October 9, 2017, you uploaded a letter from your employer into your NYSOH account.

On October 10, 2017, NYSOH reviewed the income documentation you submitted on October 9, 2017, and determined it was sufficient to verify your household income. NYSOH recalculated your household income based on this information, updated the income in your application based on this recalculation, and then submitted an application on your behalf.

That day, a preliminary eligibility determination was prepared stating that you were eligible for a tax credit of up to $286.00 per month to help you pay for your health coverage, and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective November 1, 2017. That notice also stated that you were not eligible for Medicaid because your income was over the allowable income limits for that program.

Also on October 10, 2017, you contacted NYSOH's Account Review Unit to appeal your August 31, 2017 eligibility determination insofar as you were not eligible for Medicaid for April 2017, May 2017 and June 2017, and your October 10, 2017 eligibility determination insofar as you were not eligible for Medicaid in October 2017, and because you were seeking Medicaid coverage retroactively for July 2017, August 2017, and September 2017.

Also on October 10, 2017, you uploaded a letter to NYSOH clarifying that you are paid bi-weekly, and resubmitted the letter from your employer.

On October 11, 2017, NYSOH issued an eligibility determination based on your October 10, 2017 application. This notice was consistent with its October 10, 2017 preliminary eligibility determination, stating that you were eligible for a tax credit of up to $286.00 per month and eligible to receive cost-sharing reductions, effective November 1, 2017.

On October 18, 2017, you uploaded paystubs for April 2017 and May 2017.

On October 24, 2017, NYSOH verified the paystubs you uploaded for April 2017. On October 25, 2017, NYSOH issued a notice of retroactive Medicaid enrollment coverage stating that you were eligible for Medicaid for April 2017.

On November 22, 2017, NYSOH verified the paystubs you uploaded for May 2017. On November 23, 2017, NYSOH issued a notice of retroactive Medicaid enrollment coverage stating that you were eligible for Medicaid for May 2017.

On November 30, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing held open until December 15, 2017, to allow you time to submit paystubs for the months of June 2017, July 2017, August 2017, September 2017, and October 2017.

As of December 19, 2017, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

1) You testified that you are seeking Medicaid coverage for the months of June 2017, July 2017, August 2017, September 2017, and October 2017.

2) You testified, and the record reflects, that after you filed your appeal, you were granted retroactive Medicaid for the months of April 2017 and May 2017, so you are no longer seeking retroactive Medicaid for those months.

3) According to your NYSOH account, on October 10, 2017, NYSOH recalculated your annual household income to be $27,300.00, consisting of $300.00 per week you earn in employment income, and $450.00 bi-weekly you earn in employment income. NYSOH updated your household income in your application to be $27,300.00 based on this recalculation.

4) You testified that an annual household income of $27,300.00, which included the $300.00 per week additional income, was incorrect.

5) You testified that you have only one employer, and that you earn an average of $450.00 every two weeks before taxes.

6) You provided a letter from your employer, dated October 9, 2017, that states you are employed as an [redacted] and are paid bi-

weekly and that on average receive a gross amount of $450.00 per paycheck (*see* Document [redacted]).

7) You testified that you expect to file your 2017 federal income tax return as single, and you will not claim any dependents.

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

9) You reside in Richmond County, New York.

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 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 $11,880.00 for a single-person household (81 Fed. Reg. 4036).

On the date of your application, that was the 2017 FPL, which is $12,060.00 for a single-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).

Verification Process

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i), 42 CFR § 435.945).

If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f) 42 CFR § 435.952).

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 single-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).

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)).

De Novo Review

The NYSOH Appeals Unit must review each appeal de novo and "consider all relevant facts and evidence adduced during the appeals process" (45 CFR § 155.535(f)). "De novo review means a review of an appeal without deference to prior decisions in the case" (45 CFR § 155.500).

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 under review is whether NYSOH properly determined that you were not eligible for Medicaid for the month of June 2017.

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income. If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence.

You submitted an application for financial assistance on July 17, 2017. The income amount that was entered into this application did not match federal and state data sources. As a result, on July 18, 2017, NYSOH issued a notice requesting that you submit additional documentation to confirm your income by August 1, 2017.

On August 31, 2017, NYSOH issued a notice of determination stating that you were not eligible for Medicaid for April 1, 2017 through June 30, 2017 because you failed to provide proof of your household income to confirm your Medicaid eligibility.

The Hearing Officer allowed you time to submit income documentation showing the income you received in June 2017. As of the close of the record, no documentation was received that would allow for an analysis of your monthly income and eligibility for Medicaid in the month of June 2017.

Since you failed to provide sufficient documentation of your income for the month of June 2017, NYSOH Appeals Unit will not disturb the August 31, 2017 eligibility determination finding you not eligible for Medicaid in the month of June 2017. Accordingly, the August 31, 2017 eligibility determination is AFFIRMED.

The second issue under review is whether NYSOH properly determined that you were eligible to receive APTC of up to $286.00 per month with cost-sharing reductions.

On October 9, 2017, you updated your NYSOH account by uploading a letter from your employer that stated that you earn a gross salary of $450.00 on a bi-weekly basis. A NYSOH representative reviewed the letter and determined it was sufficient to verify your household income. NYSOH then submitted an application on your behalf on October 10, 2017

However, in the October 10, 2017 application, the NYSOH representative listed income amounts which included $300.00 weekly employment income ($300.00 x 52 weeks = $15,600.00) and $450.00 bi-weekly employment income ($450.00 x 26 weeks = $11,700.00). This resulted in an annual household income of $27,300.00.

You testified that in 2017 you had only one employer. You testified that you do not receive $300.00 per week, but that you do receive a bi-weekly salary on average at $450.00 per week. On October 9, 2017, you provided supporting documentation in the form of a letter from your employer that states you are paid a bi-weekly salary of approximately $450.00, which corroborates your testimony regarding your income for October 2017.

As such, it is reasonable to conclude that NYSOH miscalculated your annual household income. As such, the October 10, 2017 application erroneously included an additional amount of $300.00 in weekly employment income ($15,600.00), which when added to your actual income of $11,700.00 resulted in an increased annual household income of $27,300.00.

Since the October 11, 2017 eligibility determination notice was premised on an incorrect annual household income as miscalculated by NYSOH, it is not supported by the record and is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your household eligibility for financial assistance as of October 10, 2017, based on a one-person household and an annual household income of $11,700.00, which is $900.00 per month, for an individual residing in Richmond County, New York.

The third issue under review is whether you were eligible for retroactive Medicaid for the months of July 2017, August 2017, and September 2017.

To date, NYSOH has not made a determination as to your eligibility for Medicaid for July, August, and September 2017.

Here, the lack of a notice of eligibility determination on the issue of your eligibility for Medicaid retroactively for the months of July 2017, August 2017, and September 2017, does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to the notice of eligibility determination had it been issued. Therefore, the issue under review is whether you were eligible for Medicaid coverage retroactively for the months of July 2017, August 2017 and September 2017.

You are in a one-person household based on your tax filing status.

On October 10, 2017, an application for financial assistance was submitted on your behalf by NYSOH.

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.

You testified that you are seeking Medicaid for July 2017, August 2017, and September 2017. Since Medicaid coverage can be made effective for up to three months prior to an application, your request for retroactive Medicaid for the months of July 2017, August 2017, and September 2017 may be considered because they are within the three months prior to your October 10, 2017 application.

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 July 2017, August 2017 and September 2017, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,387.00 per month. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during July 2017, August 2017, and September 2017.

To determine your eligibility for Medicaid retroactively for these months, NYSOH is required to verify the income you received in each of those months. To this end, the Hearing Officer allowed you time to submit income documentation showing the income you received in the months of July 2017, August 2017, and September 2017. As of the close of the record, no documentation was received that would allow for an analysis of your monthly income and eligibility for those months.

Therefore, you failed to sufficiently establish facts that would permit a finding that you were eligible for Medicaid for the months of July 2017, August 2017 or September 2017.

Decision

The August 31, 2017 eligibility determination notice is AFFIRMED.

The October 11, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your household eligibility for financial assistance as of October 10, 2017 based on a one-person household and a monthly income of $900.00, for an individual residing in Richmond County, NY, and to notify you accordingly.

There is insufficient evidence to establish a finding that you were eligible for Medicaid for the months of June 2017, July 2017, August 2017, or September 2017.

Effective Date of this Decision: January 9, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility for October 2017.

Your case is sent back to NYSOH to redetermine your eligibility for financial assistance as of October 10, 2017.

You are not eligible for Medicaid in the months of June 2017, July 2017, August 2017 or September 2017.

This decision has no effect on any subsequent determination made by NYSOH.

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 August 31, 2017 eligibility determination notice is AFFIRMED.

The October 11, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your household eligibility for financial assistance as of October 10, 2017 based on a one-person household and a monthly income of $900.00, for an individual residing in Richmond County, NY, and to notify you accordingly.

There is insufficient evidence to establish a finding that you were eligible for Medicaid for the months of June 2017, July 2017, August 2017, or September 2017.

This decision has no effect on any subsequent determination made by NYSOH.

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)

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).

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।

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)

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).

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