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

Notice of Decision

Decision Date: March 2, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025454

[redacted]

Dear [redacted],

On February 13, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's September 30, 2017 eligibility determination notice, and November 7, 2017 eligibility determination notice, and November 17, 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 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).

This page intentionally left blank.

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

Decision

Decision Date: March 2, 2018

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000025454

[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 for Medicaid effective November 1, 2017?

Did NY State of Health properly determine that you no longer qualified for and were disenrolled from Medicaid and your Medicaid Managed Care plan, effective November 30, 2017?

Did NY State of Health properly determine that you were eligible to receive up to $308.00 per month in advance payments of the premium tax credit, effective January 1, 2018?

Did NY State of Health properly determine that you were eligible for cost-sharing reductions, effective January 1, 2018?

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

Also on November 16, 2016, NYSOH issued an enrollment notice stating that you were enrolled in a Medicaid Managed Care plan with a plan enrollment start date of November 1, 2016.

On August 21, 2017, you updated your application for financial assistance.

On August 22, 2017, NYSOH issued a notice of eligibility determination stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until October 31, 2017 because certain individuals determined eligible for Medicaid remain eligible for 12 continuous months from the date that they were determined eligible. This eligibility was effective as of August 1, 2017.

On September 5, 2017, NYSOH issued a notice that it was time to renew your health insurance for the upcoming coverage year. That notice stated that, based on information from federal and state sources, NYSOH could not make a decision about whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by October 15, 2017 or you might lose your coverage and financial assistance.

On September 19, 2017, a certified application counselor submitted an application on your behalf.

On September 22, 2017, NYSOH issued a notice of enrollment confirmation stating that you remained enrolled in a Medicaid Managed Care plan with a plan enrollment start date of November 1, 2016.

On September 30, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid because your household income of $14,400.00 was at or below the allowable income limit. This eligibility was effective as of November 1, 2017.

On November 6, 2017, NYSOH received your updated application for health insurance, specifically, the income information was updated.

On November 7, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to $298.00 in advance payments of the premium tax credit (APTC) as well as cost-sharing reductions if you enrolled in a silver level qualified health plan, both effective December 1, 2017. That notice also stated that you were no longer eligible for Medicaid, effective November 30, 2017, and not eligible for the Essential Plan because your annual household income was over the allowable income limits for those programs.

On November 7, 2017, NYSOH issued a disenrollment notice stating that your coverage in your Medicaid Managed Care plan would end on November 30, 2017. This was because you were no longer eligible for Medicaid.

On November 16, 2017, you updated your application for financial assistance with health insurance.

On November 17, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to $308.00 per month in APTC as well as cost-sharing reductions if you enrolled in a silver level qualified health plan, both effective January 1, 2018. That notice stated that you were not eligible for the Essential Plan or Medicaid because your annual household income was over the allowable income limits for those programs.

On December 6, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were not found eligible for 12 months of continuous Medicaid Coverage and not found eligible for Medicaid for the 2018 coverage year.

On December 20, 2017, NYSOH issued a notice stating that you were eligible for Medicaid for a limited time, effective December 1, 2017. This was because you had been granted Aid to Continue pending the outcome of your appeal.

Also on December 20, 2017, NYSOH issued an enrollment confirmation notice stating that you were enrolled in a Medicaid Managed Care plan with a plan enrollment start date of December 1, 2017.

On February 13, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open until February 27, 2018 to allow you time to submit supporting documents.

Also on February 13, 2018, the Appeals Unit received via fax your 2017 W-2 and your 2017 Social Security Award letter. These documents were collectively marked as Appellant's Exhibit #1 and incorporated into the record.

On February 20, 2017, the Appeals Unit received via fax a letter from your employer listing your pay dates and gross pay for September 2017 and November 2017. This document was marked as Appellant's Exhibit #2 and 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 expect to file your 2017 federal income tax return as single and will not claim any dependents on that return.

2) On September 19, 2017, a certified application counselor submitted an application on your behalf. That application listed annual household income of $14,040.00 consisting in wages from employment. This application also indicated that you would be claiming your child as a dependent.

3) You testified that in 2017 you had gross income from wages of $16,216.89 and Social Security Benefits of approximately $1,700.00 per month, which benefits began in March or April of 2017.

4) On November 6, 2017, you contacted NYSOH and updated your application for financial assistance. You removed your child as a dependent in that application. That application listed annual household income of $26,380.00 consisting of $8,400.00 in wages from employment and $1,798.00 per month for ten months in Social Security Benefits.

5) On November 16, 2017, you contacted NYSOH and updated your application for financial assistance. That application listed annual household income of $29,976.00 consisting of $8,400.00 in wages from employment and $1,798.00 per month for twelve months in Social Security Benefits.

6) You submitted a Social Security Benefit award letter stating that beginning March 18, 2017 you will begin receiving $1,858.00 per month.

7) You testified that for 2018 your monthly Social Security Benefit has increased by $30.00 per month.

8) You submitted your 2017 W-2 which shows gross earnings of $16,216.89.

9) You testified that you had one employer throughout 2017, that you continue to work for the same employer, and that you anticipate that your 2018 earnings will be similar to your 2017 earnings.

10) You submitted a letter from your employer which shows that on September 5, 2017 you received gross pay of $987.50, on September 18, 2018 you received gross pay of $756.25, on November 1, 2017 you received gross pay of $825.00, and on November 15, 2017 you received gross pay of $687.50.

11) You testified that in September 2017 and November 2017, your only sources of income where your wages from employment and your monthly Social Security Benefit.

12) You testified that you do not anticipate claiming any deductions on your 2017 or 2018 tax return.

13) You testified that you reside in Queens 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).

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).

Advance Payments of Premium Tax Credit for 2017

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 September 19, 2017 and November 6, 2017 applications, that was the 2016 FPL, which is $11,880.00 for a one-person household (81 Fed. Reg. 4036.).

For annual household income in the range of at least 200% but less than 250% of the 2016 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).

Advance Payments of Premium Tax Credit for 2018

The taxpayer's expected contribution amount is the amount that the taxpayer is expected to spend on health insurance premiums. The expected contribution for 2018 is set by federal law at 2.01% to 9.56% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3, IRS Rev. Proc. 2017-36).

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 November 16, 2017 application, that was the 2017 FPL, which is $12,060.00 for a one-person household (82 Federal Register 8831).

For annual household income in the range of at least 200% but less than 250% of the 2017 FPL, the expected contribution is between 6.34% and 8.10% of the household income (26 CFR § 1.36B-3(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2017-36).

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 September 19, 2017 and November 6, 2017 applications, that was the 2016 FPL, which is $11,880.00 for a one-person household (81 Fed. Reg. 4036.). On the date of your November 16, 2017 application, that was the 2017 FPL, which is $12,060.00 for a one-person household (82 Federal Register 8831).

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 for Adults between the Ages of 19 and 65</u>

Medicaid through NYSOH can be provided 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), 435.911(b)(1), 435.603(d)(4); NY Social Services Law § 366(1)(b)).

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).

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 applications that was the 2017 FPL, which is $12,060.00 for a one-person household (82 Fed. Reg. 8831).

Medicaid Continuous Coverage

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

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

Modified Adjusted Gross Income

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

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for Medicaid effective November 1, 2017.

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

On your September 19, 2017 application, you attested to an expected household income of $14,040.00.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 64 who meet the non-financial requirements and have a household MAGI 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 $14,040.00 is 116.42% of the 2017 FPL, NYSOH properly found you to be eligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, the record reflects that this application failed to include your Social Security benefits.

Therefore, your household income at the time of the September 19, 2017 application was $34,796.89 (10 months of Social Security Benefits at $18,580.00 plus $16,216.89 in wages). Since $34,796.89 is 288.53% of the 2017 FPL, it is greater than the allowable Medicaid limit.

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 and a Social Security Benefit award letter that show in September 2017 you received $3,601.75.

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 received $3,601.75 in September 2017 you did not qualify for Medicaid on the basis of monthly income as of the date of your September 19, 2017 application.

Therefore, the September 19, 2017 eligibility determination notice finding you eligible for Medicaid is not supported by the record and is RESCINDED.

The second issue is whether NYSOH properly determined that you no longer qualified for and were disenrolled from Medicaid and your Medicaid Managed Care plan, effective November 30, 2017.

On November 6, 2017, you updated your application for financial assistance.

The application that was submitted on November 6, 2017 listed an annual household income of $26,280.00. Since $26,280.00 is 217.91% of the 2017 FPL, it is greater than the allowable Medicaid limit.

You submitted paystubs and a Social Security Benefit award letter that show in November 2016 you received $3,370.60. As this is greater than 138% of the FPL, which is $1,387.00 per month, you did not qualify for Medicaid on the basis of monthly income as of the November 6, 2017 application.

Once a person is found eligible for Medicaid, they remain eligible for Medicaid for 12 continuous months whether or not their income increases. This is referred to as “continuous coverage.”

However, since the September 19, 2017 eligibility determination notice was issued based on incorrect information and is not supported by the record, and there was no subsequent determination finding you eligible for Medicaid, the continuous coverage policy does not apply to you. Therefore, the November 7, 2017 eligibility determination notice is AFFIRMED insofar as it found you no longer eligible for Medicaid.

The third issue is whether NYSOH properly determined that you were eligible for up to $308.00 per month in APTC, effective January 1, 2018.

The application that was submitted on November 16, 2017 listed an annual household income of $29,976.00 and the eligibility determination relied upon that information.

You expected to file your 2018 income tax return as single and will not claim any dependents on that tax return. Therefore, you are in a one-person household.

You reside in Queens County, where the second lowest cost silver plan available for an individual through NYSOH costs $509.30 per month.

An annual income of $29,976.00 is 248.56% of the 2017 FPL for a one-person household. At 248.56% of the FPL, the expected contribution to the cost of the health insurance premium is 8.05% of income, or $201.07 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 ($509.30 per month) minus your expected contribution ($201.07 per month), which equals $308.23 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $308.00 per month in APTC.

The fourth issue is whether you were properly determined 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 $29,976.00 is 248.56% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

The fifth issue under review is whether NYSOH properly determined that you were ineligible for the Essential Plan.

The Essential Plan is generally 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 $12,060.00 for a one-person household. Since an annual household income of $29,976.00 is 248.56% of the 2017 FPL, NYSOH correctly found you to be ineligible for the Essential Plan.

The sixth 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 $29,976.00 is 248.56% 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 and a Social Security Benefit award letter that shows in November 2017 you received $3,370.50.

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 received $3,370.50 in November 2017, you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the November 17, 2017 eligibility determination notice properly stated that, based on the information you provided, you were eligible for up to $308.00 per month in APTC, eligible for cost-sharing reductions, ineligible for the Essential Plan and ineligible for Medicaid, it is correct and is AFFIRMED.

Following the hearing, you provided documentation that your annual expected income for 2018 is $38,872.89 ($1,888.00 per month in Social Security Benefits and $16,216.89 in wages). Therefore, your case is RETURNED to NYSOH to redetermine your eligibility based on a household of one residing in Queens County with an annual expected income of $38,872.89.

Decision

The September 19, 2017 eligibility determination notice finding you eligible for Medicaid is RESCINDED.

The November 7, 2017 eligibility determination notice is AFFIRMED insofar as it found you no longer eligible for Medicaid.

The November 17, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility as of the date of this decision based on a household of one residing in Queens County with an annual expected income of $38,872.89.

Effective Date of this Decision: March 2, 2018

How this Decision Affects Your Eligibility

You were incorrectly found eligible for Medicaid, effective November 1, 2017.

NYSOH properly found you eligible for up to $308.00 per month in APTC and cost-sharing reductions, effective January 1, 2018, and ineligible for the Essential Plan and Medicaid, based on the information in your November 16, 2017 application.

Your case is being sent back to NYSOH to redetermine your eligibility based on the information presented during the hearing. You will receive an eligibility determination notice informing you of your new eligibility.

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 September 19, 2017 eligibility determination notice finding you eligible for Medicaid is RESCINDED.

The November 7, 2017 eligibility determination notice is AFFIRMED insofar as it found you no longer eligible for Medicaid.

You were incorrectly found eligible for Medicaid, effective November 1, 2017.

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).

The November 17, 2017 eligibility determination notice is AFFIRMED.

NYSOH properly found you eligible for up to $308.00 per month in APTC and cost-sharing reductions, effective January 1, 2018, and ineligible for the Essential Plan and Medicaid, based on the information in your November 16, 2017 application.

Your case is RETURNED to NYSOH to redetermine your eligibility as of the date of this decision based on a household of one residing in Queens County with an annual expected income of $38,872.89.

Your case is being sent back to NYSOH to redetermine your eligibility based on the information presented during the hearing. You will receive an eligibility determination notice informing you of your new eligibility.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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).