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

Notice of Decision

Decision Date: March 9, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025931

[redacted]

Dear [redacted],

On February 21, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 2, 2017 eligibility determination.

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).

This page intentionally left blank.

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

Decision

Decision Date: March 9, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025931

[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 eligible to receive up to $373.82 per month in advance payments of the premium tax credit, effective January 1, 2018?
>
> Did NYSOH properly determine that you were eligible for cost-sharing reductions?
>
> Did NYSOH properly determine that you were not eligible for the Essential Plan?
>
> Did NYSOH properly determine that you were not eligible for Medicaid?

Procedural History

On December 20, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for the Essential Plan, effective February 1, 2017. You were subsequently enrolled into a MetroPlus Essential Plan with dental and vision coverage, beginning February 1, 2017.

On December 2, 2017, NYSOH issued a renewal notice stating that it was time to renew your application for financial assistance for 2018. The notice stated that, based on information available from state and federal data sources, you were eligible to receive up to $373.82 per month in APTC, and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan (QHP),

effective February 1, 2018. The notice advised you to select a health plan for enrollment between December 16, 2017 and January 18, 2018.

On December 6, 2017, you uploaded documentation to your NYSOH account.

On December 17, 2017, NYSOH issued a disenrollment notice stating that your enrollment in your Essential Plan coverage was ending, effective January 31, 2018, because you were no longer eligible to remain enrolled in Essential Plan coverage.

On December 18, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination contained in the renewal notice, insofar as you were no longer eligible for the Essential Plan. You also requested Aid to Continue, pending the outcome of your appeal.

On January 5, 2018, NYSOH issued a notice stating that you were eligible for the Essential Plan with a $20.00 monthly premium for a limited time, effective February 1, 2018. This was because you had been granted Aid to Continue pending the outcome of your appeal.

On January 5, 2018, NYSOH issued an enrollment confirmation notice stating that you were enrolled in an Essential Plan, beginning February 1, 2018. This was also because your request for Aid to Continue was granted, pending the outcome of your appeal.

On January 25, 2018, you uploaded documentation to your NYSOH account.

On February 21, 2018 you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) You testified that you expect to file your tax return for 2018 with a tax filing status of single. You will claim no dependents on that tax return.

2) The eligibility determination that was contained in the renewal notice was based on information available to NYSOH from state and federal data sources which showed that your expected annual income for 2018 was between $24,120.00 and $48,240.00.

3) You testified that you were earning $11.00 an hour in 2017, and that your hourly rate was raised to $13.00 an hour as of January 1, 2018 because the minimum wage was raised to that amount.

4) You testified that you usually work forty hours per week and that, if you work over forty hours, you earn the same rate of pay and do not earn anything extra for overtime.

5) You testified that you are paid weekly.

6) On December 6, 2017, you uploaded four weekly paystubs to your NYSOH account for the following dates and gross pay:

    a. 11/15/2017: $490.38;
    b. 11/22/2017: $490.38;
    c. 11/29/2017: $470.25;
    d. 12/6/2017: $490.05 (Document [redacted]).

7) You testified that you worked full-time in the month of December 2017, and that you would have worked at least forty hours per week in that month.

8) On January 22, 2018, you uploaded documentation to your NYSOH account consisting of a letter from your sister regarding your monthly contributions to rent and household expenses, along with copies of bills for electric, phone, internet, rent, and an IRS tax repayment agreement (Document [redacted]).

9) On January 25, 2018, you uploaded documentation to your NYSOH account consisting of a cover letter from you detailing your monthly income and expenses and explaining that you do not feel you can afford the cost of a QHP; the documentation you uploaded on January 22, 2018; a copy of a MetroCard with receipt; four weekly paystubs for the following dates and gross amounts:

    a. 1/3/18: $471.13;
    b. 1/10/18: $553.54;
    c. 1/17/18: $567.71;
    d. 1/24/18: $588.90 (Document [redacted]).

10) You testified that the income amounts in those paystubs are representative of your average weekly earnings.

11) Your application states that you will not be taking any deductions on your 2018 tax return, and you confirmed this in your testimony.

12) Your application states that you live in Kings County.

13) You testified that you are [redacted], and that you need affordable insurance that will provide the care you require.

14) You testified that the copays and other costs associated with a QHP are not affordable to you.

15) You testified that you have bills, including rent, utilities, and transportation, as well as food and incidentals, and that your expenses do not leave you with enough money to afford a QHP.

16) You testified that you believe the cost of living should be taken into consideration when determining your eligibility for financial assistance.

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

APTC are generally available to a person who is eligible to enroll in a qualified health plan 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 qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 26 CFR § 1.36B-2, 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

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 your eligibility was determined, 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).

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 are available to a person who (1) is eligible to enroll in a qualified health plan 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 qualified health plan (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 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 your eligibility was determined, that was the 2017 FPL, which is $12,060.00 for a one-person household (82 Fed. Reg. 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/downloads/ny-blueprint.pdf).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a $20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

The Essential Plan is considered minimum essential coverage; therefore, a person who is eligible for the Essential Plan is not eligible for any premium tax credit because they are eligible for minimum essential coverage through the individual market (*see* 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

Medicaid

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date your eligibility was determined, that was the 2017 FPL, which is $12,060.00 for a one-person household (82 Fed. Reg. 8831).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

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)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income (*id*.).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible to receive up to $373.82 per month in APTC.

In its renewal notice dated December 2, 2017, NYSOH informed you that your eligibility was determined based on information available from state and federal data sources. However, you testified that your income changed as of January 1, 2018, and you have submitted income documentation since the renewal notice was issued. Therefore, your eligibility is being reviewed based on the updated income information you have provided to NYSOH. he information.

You are in a one-person household. You expect to file your 2018 income tax return as single and will claim no dependents on that tax return.

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

The income documentation you uploaded on January 25, 2018 shows that your average weekly income is $545.32. Therefore, your expected annual income for 2018 is approximately $28,356.64 ($545.32 times 52 weeks).

During the hearing, you testified that you feel your current expenses, which include rent, electricity, and other living expenses, should be considered when calculating your annual household income. Since the Internal Revenue Service rules do not allow living expenses such as rent, utilities, cable, and phone to be deducted from the calculation of your adjusted gross income, they cannot be deducted when the NYSOH computes your modified adjusted gross income for APTC purposes. Therefore, your household income, for purposes of your eligibility for financial assistance with the cost of health insurance through NYSOH, is $28,356.64.

An annual income of $28,356.64 is 235.13% of the 2017 FPL for a one-person household. At 235.13% of the FPL, the expected contribution to the cost of the health insurance premium is 7.58% of income, or $179.12 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 ($179.12 per month), which equals $330.18 per month. Therefore, rounding to the nearest dollar, you are eligible for up to $330.00 per month in APTC, based on the income information you have provided.

The second issue under review 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 $28,356.64 is 235.13% of the applicable FPL, you are eligible for cost sharing reductions, if you enroll in a silver level QHP.

The third issue under review is whether NYSOH properly determined 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 $28,356.64 is 235.13% of the 2017 FPL, you are ineligible for the Essential Plan.

The fourth issue under review is whether NYSOH properly determined that you were ineligible for Medicaid.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $12,060.00 for a one-person household. Since $28,356.64 is 235.13% of the 2017 FPL, you are ineligible for Medicaid on an expected annual income basis.

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 testified that you worked approximately forty hours per week in December 2017, and that you were earning $11.00 an hour. Therefore, your December 2017 income was roughly $1,760.00 ($440.00 per week times four weeks).

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, according to your testimony, you earned approximately $1,760.00 in December 2017, you do not qualify for Medicaid based on monthly income as of the date of your application.

As the eligibility determination contained in the December 2, 2017 notice was based on data sources available to NYSOH, and as you have provided more accurate income information, the December 2, 2017 eligibility determination is not reviewed in this decision.

Instead, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance, based on a one-person household with an expected annual income of $28,356.64, residing in Kings County.

NYSOH is directed to notify you in writing of your new eligibility, and to assist you in enrolling in a health plan once your eligibility is determined.

Decision

The eligibility determination contained in the December 2, 2017 renewal notice is not reviewed herein.

You are not eligible for the Essential Plan, based on the income information you provided after the renewal notice was issued, and during the hearing.

You are not eligible for Medicaid, based on the income information you provided after the renewal notice was issued, and during the hearing.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance for 2018 based on a one-person household with an expected annual income of $28,256.64, residing in Kings County.

NYSOH is directed to notify you in writing of your new eligibility, and to assist you in enrolling in a health plan after your eligibility is determined.

Effective Date of this Decision: March 9, 2018

How this Decision Affects Your Eligibility

You are not eligible for the Essential Plan, based on the income documentation you have provided.

You are not eligible for Medicaid, based on the income documentation you have provided.

Your case is being sent back to NYSOH for a redetermination of your eligibility for financial assistance for 2018, based on the income documentation you provided.

NYSOH will notify you in writing of your eligibility, and will assist you in enrolling in a health plan once your eligibility has been determined.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the 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 eligibility determination contained in the December 2, 2017 renewal notice is not reviewed herein.

You are not eligible for the Essential Plan, based on the income information you provided after the renewal notice was issued, and during the hearing.

You are not eligible for Medicaid, based on the income information you provided after the renewal notice was issued, and during the hearing.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance for 2018 based on a one-person household with an expected annual income of $28,256.64, residing in Kings County.

NYSOH is directed to notify you in writing of your new eligibility, and to assist you in enrolling in a health plan after your eligibility is determined.

You are not eligible for the Essential Plan, based on the income documentation you have provided.

You are not eligible for Medicaid, based on the income documentation you have provided.

Your case is being sent back to NYSOH for a redetermination of your eligibility for financial assistance for 2018, based on the income documentation you provided.

NYSOH will notify you in writing of your eligibility, and will assist you in enrolling in a health plan once your eligibility has been determined.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[redacted]

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

Getting Help in a Language Other than English

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

Español (Spanish)

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

中文 (Traditional Chinese)

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

Kreyòl Ayisyen (Haitian Creole)

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

中文 (Simplified Chinese)

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

Italiano (Italian)

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

한국어 (Korean)

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

Русский (Russian)

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

العربية (Arabic)

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

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).