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

Notice of Decision

Decision Date: April 2, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027820

Dear [redacted]

On March 21, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's January 26, 2018 eligibility determination notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the NY State of Health Account ID at the top of this notice.

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

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

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nystateofhealth
The Official Health Plan Marketplace

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

Decision

Decision Date: April 2, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000027820

Issues

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

> Did NY State of Health properly determine that you were eligible to receive up to $446.00 per month in advance payments of the premium tax credit, effective March 1, 2018?
>
> Did NY State of Health properly determine that you were eligible for cost-sharing reductions?
>
> Did NY State of Health properly determine that you were ineligible for the Essential Plan?
>
> Did NY State of Health properly determine that you were ineligible for Medicaid?

Procedural History

On January 25, 2018, NYSOH received your updated application for financial assistance with health insurance. That day, a preliminary eligibility determination was prepared stating that you were eligible to receive up to $446.00 per month in advance payments of the premium tax credit (APTC) and cost-sharing reductions, effective March 1, 2018.

Also on January 25, 2018, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination notice insofar as you were not eligible for an increased amount of financial assistance.

On January 26, 2018, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to $446.00 in APTC, as well as cost-sharing reductions if you enrolled in a silver-level qualified health plan, both effective March 1, 2018. That notice also stated that you were not eligible for Medicaid because your annual household income was over the allowable income limit for that program and that you were not eligible for the Essential Plan because you must be under the age of 65 years of age, not eligible to enroll into other coverage, and have income below $32,480.00, which is the income threshold for the Essential Plan.

Also on January 26, 2018, NYSOH issued a plan enrollment notice confirming your enrollment in a silver-level qualified health plan with the application of your APTC, both effective March 1, 2018.

On March 15, 2018, NYSOH issued a plan disenrollment notice stating that you were terminated from your qualified health plan coverage, effective March 1, 2018. This notice stated that your coverage had ended because you did not pay your insurance bill by the payment deadline.

On March 21, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, Spanish Interpreter # and Spanish Interpreter # assisted. The record was developed during the hearing and left open until April 5, 2018, to allow you time to submit supporting documents.

On March 27, 2018, NYSOH received your supporting documents that were uploaded to your NYSOH account. The documents were made incorporated into the record as "Appellant's Exhibit #1 and the record was closed.

Findings of Fact

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

1) According to your NYSOH account, you expect to file your tax return for 2018 with a tax filing status of head of household and will claim one dependent on that tax return.

2) You testified that you had custody of your grandchild when you filed your January 25, 2018 application. However, in late February 2018, the Family Court Judge returned your grandchild back to his mother and he is no longer living with you.

3) You are seeking health insurance for yourself.

4) Your application indicates that your birthday is [redacted], and that you were [redacted] as of your January 25, 2018 application.

5) You testified that you do not know whether you qualify for Medicare.

6) You testified that you have a meeting with the Social Security Administration in April 2018, to see if you qualify for Social Security Retirement benefits and Medicare, but that as of the date of hearing you are not currently receiving Medicare benefits.

7) The application that was submitted on January 25, 2018, listed an annual household income of $22,585.68, consisting of income you earn from your employment.

8) On March 26, 2018, you provided income documentation that indicates that your gross monthly income for January 2018 was $1,799.65 (*see* Appellant's Exhibit #1).

9) Your application states that you will not be taking any deductions on your 2018 tax return.

10) Your application states, and you testified, that you live in [redacted], NY.

11) You testified that you have bills, including rent and other living expenses, that you think should be deducted from your household income.

12) You testified that you are unable to afford your health insurance coverage without additional financial assistance.

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

Applicable Law and Regulations

<u>Modified Adjusted Gross Income</u>

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)).

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"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.*).

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 of your application, that was the 2017 FPL, which is $16,240.00 for a two-person household (82 Federal Register 8831).

For annual household income in the range of at least 133% but less than 150% of the 2017 FPL, the expected contribution for 2018 is between 3.02% and 4.03% 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 of your application that was the 2017 FPL, which is $16,240.00 for a two-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

An individual is eligible for enrollment in Medicaid through NYSOH (called MAGI-based Medicaid) when he or she meets certain nonfinancial criteria and has a household income that is at or below the applicable Medicaid income standard (45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

On the date of your January 25, 2018 application, that was the 2017 FPL, which is $16,240.00 for a two-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).
In general, to qualify for MAGI-based Medicaid through NYSOH, you must also be one of the following:

- An adult aged 19-64 who is not eligible for Medicare Part A or Part B,
- A pregnant woman or infant,
- A child aged 1-18, or
- A parent or caretaker relative

(45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

A caretaker relative is a relative of a dependent child by blood, adoption, or marriage, who:

- Lives with the dependent child;
- Assumes primary responsibility for the child's care; and
- Is either the child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece.

(42 CFR § 435.4; N.Y. Soc. Serv. Law § 366(1)(a)(2)(i); NY Department of Health Administrative Directive 13ADM-03)

A dependent child is a child who:

- Is under 18 years old, or is 18 years old and a full-time high school student; and

- Is deprived of parental support by at least parent due to either death, absence, physical or mental incapacity, or unemployment.

(42 CFR § 435.4; N.Y. Soc. Serv. Law § 366(b)(1)(v); NY Department of Health Administrative Directive 13ADM-03)

If an individual does not fall into one of these categories, he or she may still be eligible for non-MAGI-based Medicaid coverage through their Local Department of Social Services or the New York City Human Resources Administration (*see* N.Y. Soc. Serv. Law § 366(1)(c)).

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible to receive up to $446.00 per month in APTC.

The application that was submitted on January 25, 2018, listed an annual household income of $22,585.68 and the eligibility determination relied upon that information.

During the hearing, you testified that the amount you provided in your application was correct. However, you asked that your current expenses, which include rent, and other living expenses, be considered when calculating your annual household income.

Since the Internal Revenue Service rules do not allow living expenses such as rent or other living expenses 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 eligibility purposes. Therefore, NYSOH correctly determined your household income to be $22,585.68.

At the time of the January 25, 2018 application, you were in a two-person household. You expected to file your 2018 federal tax return with a tax filing status of head of household and claim your grandchild as your dependent.

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

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).

An annual income of $22,586.00 is 139.07% of the 2017 FPL for a two-person household. At 139.07% of the FPL, the expected contribution to the cost of the health insurance premium in 2018 is 3.38% of income, or $63.62 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 ($63.62 per month), which equals $445.68 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $446.00 per month in APTC, based on your expected annual income listed in your application.

The second issue under review is whether NYSOH properly determined that you were 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 $22,585.68 is 139.07% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions, based on the expected annual income listed in your application.

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

NYSOH must generally determine an applicant eligible for the Essential 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, (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.

On the date of your application, the relevant FPL was $16,240.00 for a two-person household. Since an annual household income of $22,585.68 is 139.07% of the 2017 FPL, you did meet the financial requirements to be found eligible for the Essential Plan as of the date of your application.

However, in order to be found eligible for the Essential Plan through NYSOH, an applicant needs to meet both the financial requirements and the non-financial requirements. One of the non-financial requirements for Essential Plan eligibility is that the applicant must be 64 years old or younger at the time of the application. Since the record indicates that on [redacted], you were [redacted] NYSOH correctly found you to be ineligible for the Essential Plan based on the non-financial requirements for Essential Plan eligibility.

The final issue on appeal is whether NYSOH properly determined that you were ineligible for Medicaid.

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).

Medicaid through NYSOH (called MAGI-based Medicaid) is available to individuals who are between the ages of 19 and 64, who are not eligible for Medicare Parts A or B; pregnant women or infants; children between the ages of 1 and 18; and parent or caretaker relatives. As a result, a person who is eligible for Medicare and/or over the age of 64 can be found eligible for MAGI-based Medicaid if they are determined to be a parent or caretaker relative of a dependent child.

Your NYSOH account indicates that you were [redacted] on the date of your January 25, 2018 application. You further testified that you have a meeting with the Social Security Administration in April 2018, to see if you qualify for Social Security Retirement benefits and Medicare, but that as of the date of hearing you are not currently receiving Medicare benefits.

You testified that, in January 2018, you were the primary caregiver to your [redacted] grandchild, meaning he lived with you and you were primarily responsible for him. According to your NYSOH account, you were [redacted] at the time. Therefore, even though you are older than 64 years of age, you might have qualified for Medicaid because on the date of your January 25, 2018 application you were the caretaker relative of a dependent child.

Medicaid can be provided through NYSOH to adults who 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 January 25, 2018 application, that was the 2017 FPL, which is $16,240.00 for a two-person household. Since $22,585.68 is 139.07% of the 2017 FPL, NYSOH properly determined that you were ineligible for Medicaid on an expected annual income basis, using the information you provided in your application.

Since the January 26, 2018 eligibility determination notice stated, based on the expected annual income and other non-financial information listed in your January 25, 2018 application, that you were eligible for up to $446.00 per month in APTC, eligible for cost-sharing reductions, ineligible for the Essential Plan, and ineligible for Medicaid, it was correct when made and is AFFIRMED.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. Medicaid becomes effective the first day of the month in which the applicant is determined eligible any time in that month. To be eligible for Medicaid, you would need to meet the non-financial criteria and have a monthly income no greater than 138% of the FPL, which is $1,893.00 per month.

You submitted four weekly paystubs for the month of January 2018, which indicate that in the month of January 2018 your monthly gross income was $1,799.65 (*see* Appellant's Exhibit #1).

Since the record now contains a more accurate representative of your monthly household income for January 2018, your case is RETURNED to NYSOH to redetermine your eligibility, as of January 25, 2018, using a two-person household with a monthly income of $1,799.65 for January 2018, for a caretaker relative of a dependent child residing in Bronx County, NY, and to notify you accordingly.

Decision

The January 26, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility, as of January 25, 2018, using a two-person household with a monthly income of $1,799.65 for January 2018, for a caretaker relative of a dependent child residing in Bronx County, NY, and to notify you accordingly.

Effective Date of this Decision: April 2, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility for financial assistance through NYSOH in 2018.

Your case is being sent back to NYSOH to redetermine your eligibility, as of January 25, 2018, based on the parameters noted above. NYSOH will notify you once this has been completed.

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 January 26, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility, as of January 25, 2018, using a two-person household with a monthly income of $1,799.65 for January 2018, for a caretaker relative of a dependent child residing in Bronx County, NY, and to notify you accordingly.

This is not a final determination of your eligibility for financial assistance through NYSOH in 2018.

Your case is being sent back to NYSOH to redetermine your eligibility, as of January 25, 2018, based on the parameters noted above. NYSOH will notify you once this has been completed.

Legal Authority

We are sending you this notice in accordance with 45 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).

A Copy of this Decision Has Been Provided To:

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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.

(Urdu) اردو

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.

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