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

Notice of Decision

Decision Date: May 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028790

[redacted]

Dear [redacted]

On April 11, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's June 2, 2017 eligibility determination notice, September 14, 2017 eligibility determination notice, and December 14, 2017 enrollment confirmation 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).

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

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

Decision

Decision Date: May 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028790

[redacted]

Issues

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

Was your appeal of NY State of Health's June 2, 2017 eligibility determination notice timely?

Was your appeal of NY State of Health's September 14, 2017 eligibility determination notice timely?

Did NY State of Health properly decline to determine your eligibility for retroactive Medicaid from June 1, 2017 through August 31, 2017?

Did NY State of Health properly determine that your enrollment in your Medicaid Managed Care plan was effective October 1, 2017?

Procedural History

On June 1, 2017, a certified application counselor submitted an application for health insurance on your behalf.

On June 2, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid coverage for the treatment of emergency medical conditions only, effective June 1, 2017.

On September 13, 2017, you updated your application for financial assistance. Specifically, you changed your citizenship status.

On September 14, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective September 1, 2017.

Also on September 14, 2017, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in a Medicaid Managed Care plan with a plan enrollment start date of October 1, 2017.

On December 13, 2017, you updated your application for financial assistance. Specifically, you indicated that you were pregnant.

On December 14, 2017, NYSOH issued a notice of eligibility determination stating that you remained eligible for Medicaid, effective December 1, 2017.

Also on December 14, 2017, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in a Medicaid Managed Care plan with a plan enrollment start date of October 1, 2017.

On February 12, 2018, you spoke to NYSOH's Account Review Unit and appealed the start date of your fee-for service Medicaid, insofar as it did not begin June 1, 2017.

On February 21, 2018, NYSOH issued a notice stating that you were eligible for Medicaid for September 1, 2017 through September 30, 2017, and that services you received from providers who accept Medicaid will be covered under regular Medicaid for this time period.

On April 10, 2018, you were scheduled for a telephone hearing with a Hearing Officer from the NYSOH Appeals Unit. You requested that day that the hearing be adjourned to a later date.

On April 11, 2018, you had an adjourned telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Under oath, you waived your right to formal notice of the hearing. During the hearing you stated that you are also appealing your enrollment in your Medicaid Managed Care plan, insofar as it did not begin September 1, 2017. The record was developed during the hearing and left open until May 2, 2018 to allow you time to submit supporting documents.

As of May 3, 2018, the Appeals Unit did not receive any documents from you and no additional documents were viewable in your NYSOH account. Therefore, the record was closed that same day and this decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

1) On June 1, 2017, a certified application counselor submitted an application to NYSOH for financial assistance on your behalf.

2) The application submitted on June 1, 2017 listed your citizenship / immigration status as “other”.

3) As a result of the June 1, 2017 application, you were found eligible for emergency Medicaid only.

4) You testified that you are a natural born United States citizen.

5) You testified that you realized there was an issue with your coverage in September 2017 and you contacted NYSOH.

6) Your NYSOH account indicates that on September 13, 2017, you contacted NYSOH and updated your application for financial assistance to indicate that you are a United States citizen.

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

8) Your NYSOH account reflects that you selected your Medicaid Managed Care plan on September 13, 2017, and that your enrollment was effective as of October 1, 2017.

9) On November 7, 2017, you contacted NYSOH. As a result, incident [redacted] was created. Notes within this incident reflect that you were seeking to be found eligible for fee-for service Medicaid for June 1, 2017 through September 30, 2017. Additional notes within this incident reflect that on January 18, 2018 the system was showing that you still had active emergency Medicaid for September 2017, despite having been found eligible for fee-for service Medicaid effective September 1, 2017.

10) A note within your NYSOH account indicates that on February 20, 2018 NYSOH corrected your coverage for September 2017 to reflect that you had fee-for service Medicaid and not emergency Medicaid for that month.

11) You testified that you did not file a tax return in 2017.

12) Your account indicates that you are not married and that you do not yet have any children.

13) You testified that you earned approximately $3,000.00 in 2017.

14) You testified that you were working in June 2017, July 2017, and August 2017.

15) On January 18, 2018, you submitted an exit interview from your employer which indicated that your last day worked was [redacted]

16) You testified that you are pregnant with one child and with a due date of [redacted] and that you have been pregnant since August 2017.

17) You testified that you are not sure what your monthly income was for June 2017, July 2017, and August 2017, however, you earned a total of $3,000.00 for all three months.

18) You testified that you reside in Herkimer County.

19) The Hearing Officer directed you to submit paystubs for June 2017, July 2017, and August 2017 and left the record open until May 2, 2018 to allow you to submit this documentation.

20) As of May 3, 2018, no additional documentation has been received via fax or upload.

21) You testified that you are seeking to be found eligible for Medicaid as of June 1, 2017 and to have your Medicaid Managed Care plan begin as of September 1, 2017.

22) You testified that you do not have any medical bills for June 2017, July 2017, or August 2017.

23) You testified that you do have an outstanding medical bill for September 2017.

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

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of

cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR §155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

Medicaid for Adults between the Ages of 19 and 65

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

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

Medicaid for Pregnant Women

Medicaid can be provided through the Marketplace 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)), N.Y. Soc. Serv. Law § 366(1)(b)).

In New York, a pregnant woman is eligible for Medicaid at a household income of 223% of the federal poverty level (FPL) for the applicable family size (42 CFR

§435.116 (c)(2); NY Department of Social Services Administrative Directive 13ADM-03).

“Family size” means the number of persons counted as members of an individual’s household. The household of a taxpayer who expects to file a return, and does not expect to be claimed as a tax dependent by anyone else, consists of the taxpayer plus all people the taxpayer expects to claim as tax dependents (42 CFR § 435.603(f)(1)).

For purposes of Medicaid eligibility, the family size of a pregnant woman includes the pregnant woman and the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, 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 application, that was the 2017 FPL, which is $16,240.00 for a two-person household (82 Fed. Reg. 8831).

Retroactive Medicaid

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of an initial application if the individual received medical services that would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time he received the services if he had applied (42 USCA § 1396A(34); 42 CFR § 435.915(a)). The Department of Health may make eligibility effective for fee-for-service Medicaid on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Medicaid Start Dates

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)).

Medicaid Managed Care plan enrollments received on or before the fifteenth day of the month are effective the first day of the following month. Enrollments received after the fifteenth day of the month are effective the first day of the second following month (Medicaid Managed Care Model Contract (Appendix H-6(b)(ii) & (iii), effective 3/1/2014 – 2/28/2019; *see* 42 USC § 1315; § 364-j(1)(c); 18 NYCRR § 360-10.3(h), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

Legal Analysis

The first issue under review is whether your appeal of NYSOH's June 2, 2017 eligibility determination notice was timely.

The record reflects that you first contacted NYSOH to file a formal appeal regarding your eligibility for emergency Medicaid effective June 1, 2017 on February 12, 2018.

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of the June 2, 2017 eligibility determination that you were eligible for emergency Medicaid only effective June 1, 2017, an appeal should have been filed by August 1, 2017.

The record reflects that the first time you contacted NYSOH following the June 2, 2017 eligibility determination notice was September 13, 2017 and that you did not file an incident regarding the finding that you were eligible for emergency Medicaid as of June 1, 2017, until November 7, 2017.

As your appeal was filed more than 60-days after the June 2, 2017 eligibility determination notice, your appeal of this notice is untimely and is DISMISSED.

The second issue is whether your appeal of NYSOH's September 14, 2017 eligibility determination notice was timely.

The record reflects that you first contacted NYSOH to file a formal appeal regarding the failure of NYSOH to determine your eligibility for retroactive Medicaid for June 1, 2017 through August 31, 2017 on February 12, 2018.

However, NYSOH has never issued an eligibility determination as to whether you were eligible for retroactive Medicaid for June 1, 2017 through August 31, 2017.

As NYSOH has never issued a notice of eligibility determination addressing your eligibility for retroactive Medicaid for June 1, 2017 through August 31, 2017, the 60-day period from which an appeal should have been filed on this issue never began to run.

Therefore, your appeal is timely and will be addressed.

The third issue under review is whether NYSOH properly declined to determine your eligibility for retroactive Medicaid from June 1, 2017 through August 31, 2017.

You submitted an application for financial assistance on September 13, 2017. Thereafter, on November 7, 2017, you requested help in paying for medical bills for June 2017, July 2017, and August 2017.

You testified that you did not file a tax return for 2017. Your account indicates that you are not married and you do not yet have any children. However, you testified that you have been pregnant since August 2017.

When calculating family size for Medicaid purposes, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman but also the number of children she expects to deliver.

Therefore, you were in a one-person household during June 2017 and July 2017, and a two-person household as of August 2017.

You submitted an application for financial assistance on September 13, 2017 and subsequently requested help in paying for medical bills for June 2017, July 2017, and August 2017. You were found eligible for Medicaid as of September 1, 2017.

When an individual file an initial application for Medicaid, his or her eligibility for retroactive Medicaid depends on the date of application. To this end, it does not matter whether or not that initial application resulted in Medicaid going forward. Instead, an individual, who has filed an initial application for Medicaid through NYSOH, has the right to be evaluated for Medicaid for the three months before the month of his or her application.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's initial application if the individual received medical services that would have been covered under Medicaid and if they would have been eligible for Medicaid in those three months had they applied.

You testified that you are seeking fee-for service Medicaid from June 1, 2017 through August 31, 2017.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

To be eligible for Medicaid in June 2017 and July 2017 you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL, which was $1,387.00 per month.

To be eligible for Medicaid in August 2017 you would have needed to meet the non-financial criteria and have an income no greater than 223% of the FPL which was $3,018.00 per month.

There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during June 2017, July 2017, or August 2017.

You testified that you were working in June 2017, July 2017, and August 2017. You provided a letter indicating that your employment ended on August 25, 2017.

You testified that you made a total of approximately $3,000.00 in June 2017, July 2017, and August 2017, but you could not recall specifically what you had earned in each month.

The Hearing Officer directed you to submit your paystubs for June 2017, July 2017, and August 2017. The record was left open until May 2, 2018 to allow you to submit this documentation. However, you submitted no additional documentation.

Therefore, there remains insufficient evidence in the record for NYSOH to determine your eligibility for retroactive Medicaid for the months of June 2017, July 2017, and August 2017.

Therefore, the September 14, 2017 eligibility determination notice which found you eligible for Medicaid effective September 1, 2017 and declined to address your eligibility for retroactive Medicaid for the months of June 2017, July 2017, and August 2017 is AFFIRMED.

The fourth issue is whether NYSOH properly determined that your enrollment in your Medicaid Managed Care plan was effective October 1, 2017.

Your NYSOH account reflects that on September 13, 2017, you updated your application for financial assistance and were found eligible for Medicaid. That same day you selected a Medicaid Managed Care plan for enrollment.

The date on which a Medicaid Managed Care plan can take effect depends on the day a person selects the plan for enrollment.

A plan that is selected from the first day to and including the fifteenth day of a month will go into effect on the first day of the following month. A plan that is selected on or after the sixteenth day of the month will go into effect on the first day of the second following month.

On September 13, 2017, you selected a Medicaid Managed Care plan, so it properly took effect on the first day of the first month following after September 2017; that is, on October 1, 2017.

Therefore, the December 14, 2017 enrollment confirmation notice stating that your enrollment in your Medicaid Managed Care plan would be effective October 1, 2017, was correct and must be AFFIRMED.

Decision

Your appeal of the June 2, 2017 eligibility determination notice is DISMISSED as untimely.

The September 14, 2017 eligibility determination notice is AFFIRMED.

The December 14, 2017 enrollment confirmation notice is AFFIRMED.

Effective Date of this Decision: May 10, 2018

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

Your eligibility for retroactive Medicaid for June 1, 2017 through August 31, 2017 has not been determined as you have failed to submit sufficient income documentation to confirm your income for those months.

The effective date of your Medicaid Managed Care plan is October 1, 2017.

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

Your appeal of the June 2, 2017 eligibility determination notice is DISMISSED as untimely.

The September 14, 2017 eligibility determination notice is AFFIRMED.

This decision does not change your eligibility.

Your eligibility for retroactive Medicaid for June 1, 2017 through August 31, 2017 has not been determined as you have failed to submit sufficient income documentation to confirm your income for those months.

The December 14, 2017 enrollment confirmation notice is AFFIRMED.

The effective date of your Medicaid Managed Care plan is October 1, 2017.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

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

Getting Help in a Language Other than English

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

Español (Spanish)

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

中文 (Traditional Chinese)

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

Kreyòl Ayisyen (Haitian Creole)

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

中文 (Simplified Chinese)

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

Italiano (Italian)

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

한국어 (Korean)

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

Русский (Russian)

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

العربية (Arabic)

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

বাংলা (Bengali)

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

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

Français (French)

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

हिंदी (Hindi)

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

日本語 (Japanese)

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

नेपाली (Nepali)

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

Polski (Polish)

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

Twi (Twi)

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

اردو (Urdu)

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

Tiếng Việt (Vietnamese)

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

אידיש (Yiddish)

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

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