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

Notice of Decision

Decision Date: December 18, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024015
AP00028807235

[redacted]

Dear [redacted]

On December 6, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 22, 2017 eligibility determination notice, October 21, 2017 eligibility determination notice and November 3, 2017 enrollment 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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STATE OF NEW YORK
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P.O. Box 11729
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Decision

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NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024015
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Issues

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

> Did NY State of Health (NYSOH) properly determine that you were not eligible for Medicaid for January 2016, February 2016 and March 31, 2016?
>
> Did NYSOH provide a timely determination of your child's Child Health Plus eligibility as of December 1, 2017?
>
> Did NYSOH properly determine that your child's eligibility for and enrollment in their Child Health Plus plan began on December 1, 2017?

Procedural History

On April 25, 2016, NYSOH received your initial application for financial assistance. That application indicated that you were pregnant.

On April 27, 2016, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective April 1, 2016, because you met the non-financial and financial criteria for a pregnant woman seeking Medicaid coverage.

On April 28, 2016, NYSOH issued an enrollment confirmation notice stating that you were enrolled in a Medicaid Managed Care plan, effective June 1, 2016.

On October 12, 2016, you updated your NYSOH account and added your newborn to your account.

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On October 13, 2016, NYSOH issued a notice of eligibility determination stating that you and your child were eligible for Medicaid, effective October 1, 2016.

On August 21, 2017, you updated your application for financial assistance and indicated that you were seeking help for paying for medical bills for January 2016, February 2016, and March 2016.

On August 22, 2017, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid for January 2016, February 2016 or March 2016. The notice stated that this is because your monthly household income for January 2016 of $1,902.00, February 2016 of $3,168.00, and March 2016 of $2,207.00, were over the allowable monthly income limit of $1,843.00

On September 2, 2017, NYSOH issued a notice that it was time to renew your child's health insurance. That notice stated that NYSOH did not have enough information form state and federal data sources to determine whether your child qualified for financial help paying for her coverage. The notice asked that you update your account by October 15, 2017 or the financial assistance your child was receiving may end.

On October 10, 2017 NYSOH received your updated application for financial assistance for your child.

On October 11, 2017, NYSOH issued a notice stating that the information in your child's application did not match what NYSOH had received from state and federal data sources and more information was needed to make a determination on your child's eligibility. The notice directed you to submit documentation of your household's income by October 25, 2017.

Also on October 11, 2017, NYSOH issued a disenrollment notice stating that your child's coverage would end on October 31, 2017. This was because your child was no longer eligible to enroll in her current plan.

On October 20, 2017, income documentation was uploaded to your NYSOH account.

On October 20, 2017, NYSOH reviewed the income documentation you submitted, updated the income information in your child's application based on that documentation, and submitted an application on your child's behalf.

On October 21, 2017, NYSOH issued a notice of eligibility determination stating that your child was eligible for Child Health Plus, effective December 1, 2017.

On November 2, 2017, you selected a Child Health Plus plan for your child for enrollment.

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).

On November 3, 2017, NYSOH issued a notice of enrollment, based on your November 2, 2017 plan selection, stating that your child was enrolled in her Child Health Plus plan effective December 1, 2017.

Also on November 3, 2017, you spoke to NYSOH's Account Review Unit. You appealed the August 22, 2017 eligibility determination notice insofar as it denied you retroactive Medicaid for the months of January 2016, February 2016 and March 2016. This appeal was assigned appeal number AP00028807235. You also appealed the November 3, 2017 determination notice insofar as your child's Child Health Plus plan began on December 1, 2017 and not on November 1, 2017. This appeal was assigned appeal number AP000000024015.

On December 6, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing held open until December 29, 2017, to allow you to submit supporting documents of your income for January 2016, February 2016 and March 2016.

On December 6, 2017, you uploaded the supporting documents to your NYSOH account, and it was incorporated into the record as Appellant's Exhibit #1, the record was closed that day.

Findings of Fact

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

1) You testified that you are seeking Medicaid for the months of January 2016, February 2016 and March 2016.

2) You testified that you were pregnant with one child in January 2016, February 2016 and March 2016.

3) You testified that you filed your 2016 federal income tax return as head of household, and claimed one dependent on that tax return.

4) You submitted an application for financial assistance on April 25, 2016.

5) You updated that application on August 21, 2017, and indicated that you were seeking help for paying for medical bills for January 2016, February 2016, and March 2016.

6) You testified that in you are paid twice a month.

7) You uploaded two paystubs for January 2016. The paystub dated January 15, 2016 shows a gross pay amount of $837.07. The paystub dated January 31, 2016 shows a gross pay amount of $1,168.70.

8) You uploaded two paystubs for February 2016. The paystub dated February 15, 2016 shows a gross pay amount of $1,517.67. The paystub dated February 29, 2016 shows a gross pay amount of $626.10.

9) You uploaded two paystubs for March 2016. The paystub dated March 15, 2016 shows a gross pay amount of $1,206.17. The paystub dated March 31, 2016 shows a gross pay amount of $591.25.

10) You testified that you did not plan take any deductions on your 2016 tax return.

11) You testified that you are also seeking to have your child's Child Health Plus plan begin on November 1, 2017 because you do not want a gap in coverage.

12) Your NYSOH account reflects that you updated your application on October 10, 2017.

13) You testified, and the record reflects, that you uploaded documents on October 20, 2017.

14) On October 20, 2017, NYSOH reviewed the documents you uploaded, and determined that it was sufficient proof of your income.

15) Your NYSOH account reflects that on November 2, 2017, you enrolled your child into a Child Health Plus plan.

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

Applicable Law and Regulations

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).

For purposes of Medicaid eligibility, 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 (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). In the months during which you are seeking retroactive coverage, that was the 2016 FPL, which is $16,020.00 for a two-person household (81 Fed. Reg. 4036).

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).

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)).

Child Health Plus

The "period of eligibility" for Child Health Plus is "that period commencing on the first day of the month during which a child is an eligible child and enrolled or recertified for enrollment on an annual basis based on all required information and documentation and ending on the last day of the twelfth month following such date," unless the CHP premiums are not timely paid or the child no longer resides in New York State, gains access to or obtains other health insurance coverage, or becomes eligible for Medicaid (NY Public Health Law § 2510(6)).

"A State must specify a method for determining the effective date of eligibility for [Child Health Plus], which can be determined based on the date of application or through any other reasonable method that ensures coordinated transition of children between [Child Health Plus] and other insurance affordability programs as family circumstances change and avoids gaps or overlaps in coverage" (42 CFR § 457.340(f)).

The State of New York has provided that a child's period of eligibility for Child Health Plus begins on the first day of the month during which a child is eligible. A child will become eligible on the first day of the next month, if the application is received by the 15th of the month; applications received after the 15th day of the month will be processed for the first day of the second following month (*see e.g.* State Plan Amendment (SPA) NY-14-0005, approved February 3, 2015 and effective January 1, 2014).

Child Health Plus – Income Verification

NYSOH is required to verify the eligibility of an applicant for CHP subsidy payments, which includes verifying the applicant's household income. If NYSOH is unable to verify the applicant's household income using available data sources, then NYSOH must request additional information from the applicant. NYSOH must provide the applicant with a reasonable period of time to furnish such information (42 CFR § 457.380; 42 CFR § 435.952(c)).

Timely Notice of Child Health Plus Eligibility

When an individual applies for insurance through NYSOH, NYSOH must determine that person's eligibility promptly and without undue delay (45 CFR § 155.310(e)(1); 42 CFR § 435.1200(b)(3)(iii)).

To assess whether an eligibility determination was untimely, NYSOH must base the time period from the date of application to the date NYSOH notifies the applicant of its decision (45 CFR § 155.310(e)(2)). However, if the applicant submits an incomplete application or there is not sufficient information for NYSOH to make an eligibility determination, then NYSOH must notify that applicant that more information is needed to complete the application (45 CFR § 155.310(k)(1)).

NYSOH must provide Medicaid applicants who are a child at least one year of age but younger than 19 years of age notice of their eligibility determination within 30 days from the date of the application (18 NYCRR §360-2.4(a)(3)(ii)). NYS has elected to use a common application for Medicaid and Child Health Plus, therefore the timeliness standards for Child Health Plus determinations are the same as those for Medicaid determinations (*see* State Plan Amendment NY-CSPA-19, approved March 22, 2012 and effective November 11, 2011).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were not eligible for Medicaid for January 2016, February 2016 and March 2016.

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. You testified that you were pregnant in January, February and March of 2016. Therefore, you were in a two-person household for each of those months because you were pregnant and your application listed you as single.

You submitted an application for financial assistance on April 25, 2016. On August 21, 2017, you updated your application for financial assistance and indicated that you were seeking help for paying for medical bills for January 2016, February 2016, and March 2016.

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

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

You testified that you are seeking Medicaid for January 2016, February 2016, and March 2016.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. As a pregnant woman, to be eligible for Medicaid in January 2016, February 2016, and March 2016, you would have needed to meet the non-financial criteria and have an income no greater than 223% of the 2016 FPL, which is $2,978.00 per month for a pregnant woman in a two-person household.

The August 22, 2017 eligibility determination notice states that you are not eligible for Medicaid for these months because your income in each of the months was over the allowable monthly income limit of $1,843.00.

In 2016, 138% of the FPL for a two-person household was $1,843.00. However, you were pregnant and in a two-person household in January 2016, February 2016 and March 2016. Your eligibility for Medicaid for these months should have been determined at 223% of the 2016 FPL, not 138% of the FPL. Therefore, NYSOH incorrectly determined that you were ineligible for Medicaid in January 2016, February 2016 and March 2016 based on an incorrect FPL level.

You uploaded two paystubs for January 2016. The paystub dated January 15, 2016 shows a gross pay amount of $837.07. The paystub dated January 31,

2016 shows a gross pay amount of $1,168.70. Therefore, the record indicates that in the month of January 2016 your gross income was $2,005.77.

You uploaded two paystubs for February 2016. The paystub dated February 15, 2016 shows a gross pay amount of $1,517.67. The paystub dated February 29, 2016 shows a gross pay amount of $626.10. Therefore, the record indicates that in the month of February 2016 your gross income was $2,143.77.

You uploaded two paystubs for March 2016. The paystub dated March 15, 2016 shows a gross pay amount of $1,206.17. The paystub dated March 31, 2016 shows a gross pay amount of $591.25. Therefore, the record indicates that in the month of March 2016 your gross income was $1,797.42.

Therefore, the August 22, 2017 eligibility determination stating that you were not eligible for Medicaid in the months of January 2016, February 2016 and March 2016 is incorrect and is RESCINDED.

Since the record now contains a more accurate representation of what your income was for the months of January 2016, February 2016 and March 2016, your case is RETURNED to NYSOH to consider your request for retroactive coverage for January 2016 based on a household income of 223% of the FPL for a two-person household, with an income of $2,005.77, for retroactive coverage for February 2016 based on a household income of 223% of the FPL for a two-person household, with an income of $2,143.77, and for retroactive coverage for March 2016 based on a household income of 223% of the FPL for a two-person household, with an income of $1,797.42.

The second issue is whether NYSOH provided you with a timely determination of your child's Child Health Plus eligibility as of December 1, 2017.

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income.

If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence.

You updated your child's application for financial assistance with health insurance on October 10, 2017. The income amount entered into this application did not match federal and state data sources. As a result, NYSOH asked that you submit additional documentation to confirm your income.

On October 20, 2017, you uploaded income documents to your NYSOH account. That same day, NYSOH determined that the income documents you provided were sufficient to verify your income. Therefore, your child's application was complete as of October 20, 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).

NYSOH must provide applicants who are a child at least one year of age but younger than 19 years of age notice of their eligibility determination within 30 days from the date of the completed application. To assess whether an eligibility determination was untimely, NYSOH must base the time period from the date of the completed application to the date NYSOH notifies the applicant of its decision.

Since your child's application was considered complete as of October 20, 2017, and NYSOH issued an eligibility determination the next day, on October 21, 2017, NYSOH issued a timely eligibility determination notice.

The third issue is whether NYSOH properly determined that your child's enrollment in her Child Health Plus plan began on December 1, 2017.

The date on which a Child Health Plus plan can take effect depends on the day a person selects the plan for enrollment. A plan that is selected between the first day and fifteenth day of a month goes into effect on the first day of the following month. A plan that is selected from the sixteenth day of the month and the end of the month goes into effect on the first day of the second following month.

You selected a Child Health Plus plan for your child on November 3, 2017, so her enrollment properly took place on the first day of the month following November; that is December 1, 2017.

Therefore, the October 21, 2017 eligibility determination stating that your child's eligibility for Child Health Plus plan was effective as of December 1, 2017 and the November 3, 2017 enrollment notice stating that your child's enrollment was effective December 1, 2017, are AFFIRMED.

Decision

The August 22, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for January 2016 based on a household income of 223% of the FPL for a two-person household, with an income of $2,005.77, for retroactive coverage for February 2016 based on a household income of 223% of the FPL for a two-person household, with an income of $2,143.77, and for retroactive coverage for March 2016 based on a household income of 223% of the FPL for a two-person household, with an income of $1,797.42.

The October 21, 2017 eligibility determination is AFFIRMED.

The November 3, 2017 enrollment notice is AFFIRMED.

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).

Effective Date of this Decision: December 18, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your Medicaid eligibility for the months of months of January 2016, February 2016 and March 2016. Your case is sent back to NYSOH to redetermine your eligibility for each of these months based on the evidence you presented at the hearing.

Your child's eligibility for Child Health Plus was effective December 1, 2017.

Your child's enrollment into a Child Health Plus plan was effective December 1, 2017.

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 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).

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

If You Have Questions about this Decision (Customer Service Resources):

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The August 22, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for retroactive coverage for January 2016 based on a household income of 223% of the FPL for a two-person household, with an income of $2,005.77, for retroactive coverage for February 2016 based on a household income of 223% of the FPL for a two-person household, with an income of $2,143.77, and for retroactive coverage for March 2016 based on a household income of 223% of the FPL for a two-person household, with an income of $1,797.42.

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility for each of these months based on the evidence you presented at the hearing.

The October 21, 2017 eligibility determination is AFFIRMED.

The November 3, 2017 enrollment notice is AFFIRMED.

Your child's eligibility for and enrollment in Child Health Plus was effective as of December 1, 2017.

Legal Authority

We are issuing this determination 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:

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 1-855-355-5777번으로 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)

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

Français (French)

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

हिंदी (Hindi)

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

日本語 (Japanese)

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

नेपाली (Nepali)

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

Polski (Polish)

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

Twi (Twi)

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

اردو (Urdu)

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

Tiếng Việt (Vietnamese)

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

אידיש (Yiddish)

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

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