Covered California
PO BOX 989725
West Sacramento, CA 95798-9725

COVERED CALIFORNIA

Your destination for affordable healthcare, including Medi-Cal

Enoch Yannapu
58 Wind Song
Milpitas, CA 95035

Your state tax form for 2020

January 09, 2021 **Case: 5187867291**

Dear Enoch Yannapu,

Form FTB 3895, California Health Insurance Marketplace Statement, is on the next page of this letter. You need this form to file your California income tax return with the Franchise Tax Board (FTB). It will allow you to report the right amount of California premium subsidy. It will also show proof of coverage for 2020.

If you got California premium subsidy or want to claim it now, you must:

- File a state tax return. You must file even if you don't usually file a state tax return or have not filed in the past.
- Use your Form FTB 3895 to fill out form FTB 3849, Premium Assistance Subsidy. Attach Form FTB 3849 to your state tax return to report the California premium subsidy amount you got each month.

IMPORTANT: You will get two tax forms this year.

This letter is about your state tax form (Form FTB 3895).

We will send you a federal tax form (IRS Form 1095-A) in a **separate envelope** before January 31. You will need it to file your federal taxes.

Note: If you are married or have a Registered Domestic Partner, you may be required to file your taxes as Married Filing Jointly. Certain exceptions apply for special circumstances. If you have questions about your tax filing status, talk to your tax preparer.

Need a digital copy? Log in to your CoveredCA.com account and go to "Documents and Correspondence" or "Secure Mailbox." Look for "2020 California Tax Form (3895) – Original." If you do not have an online account, call Covered California first for an access code.

Help with taxes
Covered California may be able to answer questions but cannot give tax advice. For help with your taxes:

- Talk to your tax adviser.
- Contact Volunteer Income Tax Assistance (VITA). VITA generally serves people who make $56,000 or less per year, persons with disabilities, the elderly and limited English-speaking taxpayers. To find help near you:
    - Go online: https://irs.treasury.gov/freetaxprep/
    - Call: 1-800-906-9887
- Visit the Franchise Tax Board's website at FTB.ca.gov. You can learn more about filing your state tax return, the California premium subsidy and the California Individual Shared Responsibility Penalty.

Questions? Please read our **Frequently Asked Questions** after your tax form. If you have a different question or think there is a mistake on your form:

- Go online: CoveredCA.com/3895
- Call Covered California: 1-800-300-1506 (TTY: 1-888-889-4500). You can call Monday through Friday 8 a.m. to 6 p.m.

Remember: *You will get two tax forms this year. Your letters may be mailed days or weeks apart in separate envelopes. Please wait until after January 31 to report a missing form.*

Thank you,

Covered California

This notice was sent to you in compliance with Section 61005 of the Revenue and Taxation Code.

Taxable Year **2020**

California Health Insurance Marketplace Statement

California Form **3895**

☐ VOID ☐ CORRECTED

Recipient's name	Initial	Last Name	Suffix	Recipient's SSN	Recipient's date of birth
Enoch		Yannapu		155299763	10/12/1987
Spouse's name	**Initial**	**Last Name**	**Suffix**	**Spouse's SSN**	**Spouse's date of birth**

Address (apt./ste, room, PO box, or PMB no.)
58 Wind Song

City(If you have a foreign address, see instructions.)	State	ZIP Code
Milpitas	CA	95035

Marketplace identifier	Marketplace-assigned policy number	Policy issuer's name
California	12331394	Kaiser
Policy start date	**Policy termination date**	☐ Repayment cap may not apply
01/01/2020	01/31/2020	

Part I Covered Individuals

	(a) Covered individual name		(b) Covered Individual SSN	(c) Covered individual date of birth	(d) Coverage start date	(e) Coverage termination date
	First name	Last name				
1	Enoch	Yannapu	155299763	10/12/1987	01/01/2020	01/31/2020
2						
3						
4						
5						

Part II Coverage Information

Month	(a) Monthly enrollment premiums	(b) Monthly second lowest cost silver plan (SLCSP) premium	(c) Monthly advance payment of premium assistance subsidy
6 January	$444.27	$444.27	0
7 February	0	0	0
8 March	0	0	0
9 April	0	0	0
10 May	0	0	0
11 June	0	0	0
12 July	0	0	0
13 August	0	0	0
14 September	0	0	0
15 October	0	0	0
16 November	0	0	0
17 December	0	0	0
18 **Annual Totals**	$444.27	$444.27	0

2020 Recipient Instructions for Form FTB 3895

California Health Insurance Marketplace Statement

What's New

Minimum Essential Coverage Individual Mandate – For taxable years beginning on or after January 1, 2020, California requires residents and their dependents to obtain and maintain monthly qualified health care coverage. Individuals who fail to maintain qualifying health care coverage for any month during taxable year 2020, may owe a penalty unless they qualify for an exemption. For more information, get the following new health care forms and instructions:

- Form FTB 3849, Premium Assistance Subsidy
- Form FTB 3853, Health Coverage Exemptions and Individual Shared Responsibility Penalty
- Form FTB 3895, California Health Insurance Marketplace Statement
- Publication 3849A, Premium Assistance Subsidy (PAS)
- Publication 3895B, California Instructions for Filing Federal Forms 1094-B and 1095-B
- Publication 3895C, California Instructions for Filing Federal Forms 1094-C and 1095-C

General Information

You received form FTB 3895, California Health Insurance Marketplace Statement because you or a family member enrolled in a qualified health plan through the California Health Insurance Marketplace (Marketplace). The term "Marketplace" refers to the California state Marketplace, Covered California. This form FTB 3895 provides information you need to complete form FTB 3849, Premium Assistance Subsidy (PAS). You must complete form FTB 3849 and file it with your tax return (Form 540, Form 540NR, or Form 540 2EZ) if any amount other than zero is shown in Part II, column (c), of this form FTB 3895 (meaning that you received financial help through advance payments of the premium assistance subsidy (also called advance subsidy payments)) or if you want to take the premium assistance subsidy. If you received the premium assistance subsidy, you are required to file a tax return regardless of California's income tax filing thresholds. The Marketplace has also reported the information on this form to the Franchise Tax Board (FTB). If you or your family members enrolled at the Marketplace in more than one qualified health plan policy, you will receive a form FTB 3895 for each policy. Check the information on this form carefully. Please contact your Marketplace if you have questions concerning its accuracy. If you or your family members were enrolled in a Marketplace catastrophic health plan or separate dental policy, you are not entitled to take a premium assistance subsidy for this coverage when you file your tax return, even if you received a form FTB 3895 for this coverage.

For information about health coverage options and financial help, go to **coveredca.com**. For information about the penalty, go to **ftb.ca.gov/healthmandate.**

VOID box. If the "VOID" box is checked at the top of the form, you previously received a form FTB 3895 for the policy described in the recipient information section. That form FTB 3895 was sent in error. You should not have received a form FTB 3895 for this policy. **Do not** use the information on this or the previously received form FTB 3895 to determine your premium assistance subsidy on form FTB 3849.

CORRECTED box. If the "CORRECTED" box is checked at the top of the form, use the information on this form FTB 3895 to determine your premium assistance subsidy and reconcile any advance subsidy payments on form FTB 3849. **Do not** use the information on the original form FTB 3895 you received for this policy.

Specific Instructions

Recipient Information

This section reports information about you, the insurance company that issued your policy, and the Marketplace where you enrolled in the coverage.

Recipient's name – You are the recipient because you are the person the Marketplace identified at enrollment who is expected to file a tax return and who, if qualified, would take the premium assistance subsidy for the year of coverage.

Recipient's SSN – This is your social security number. For your protection, this form may show only the last four digits. However, the Marketplace has reported your complete social security number to the FTB.

Recipient's date of birth – This is your date of birth.

Spouse's name/SSN/date of birth – Information about your spouse will be entered only if you and your spouse were enrolled in the same policy.

Address/City/State/Zip code – Your address is entered on these lines.

Marketplace identifier – This line identifies California as the state where you enrolled for coverage.

Marketplace-assigned policy number – This line is the policy number assigned by the Marketplace to identify the policy in which you enrolled. If you are completing Part IV of form FTB 3849, enter this number on line 30, 31, 32, or 33 box a.

Policy issuer's name – This is the name of the insurance company that issued your policy.

Policy start/termination date – These are the starting and ending dates of the policy.

Repayment cap may not apply – If this box is checked and you received advance payment of the premium assistance subsidy, get form FTB 3849 for instructions.

Part I – Covered Individuals

Line 1 through Line 5 – Part I reports information about each individual who is covered under your policy. This information includes the name, social security number, date of birth, and the starting and ending dates of coverage for each covered individual.

If advance subsidy payments are made, the only individuals listed on form FTB 3895 will be those whom you certified to the Marketplace would be in your applicable household for the year of coverage (yourself, spouse, and dependents). If you certified to the Marketplace at enrollment that one or more of the individuals who enrolled in the plan are not individuals who would be in your applicable household for the year of coverage, those individuals will not be listed on your form FTB 3895. For example, if you indicated to the Marketplace at enrollment that an individual enrolling in the policy is your adult child who will not be your dependent for the year of coverage, that adult child will receive a separate form FTB 3895 and will not be listed in Part I on your form FTB 3895.

If advance subsidy payments are made and you certify that one or more enrolled individuals are not individuals who would be in your applicable household for the year of coverage, your form FTB 3895 will include coverage information in Part II that is applicable solely to the individuals listed on your form FTB 3895, and separately issued forms FTB 3895 will include coverage information, including dollar amounts, applicable to those individuals not in your applicable household.

If advance subsidy payments weren't made and you didn't identify at enrollment the individuals who would be in your tax family for the year of coverage, form FTB 3895 will list all enrolled individuals in Part I on your form FTB 3895.

If there are more than 5 individuals covered by a policy, you will receive one or more additional forms FTB 3895 that continue Part I.

Part II – Coverage Information

Line 6 through Line 18 – Part II reports information about your insurance coverage that you will need to complete form FTB 3849 to reconcile advance subsidy payments or to take the premium assistance subsidy when you file your tax return. The Marketplace will report the amounts in columns (a), (b), and (c) on line 6 through Line 17 for each month and enter the totals on line 18. Use this information to complete form FTB 3849, line 11 or lines 12 through line 23.

Column (a). This column is the monthly premiums for the plan in which you or family members were enrolled, including premiums that you paid and premiums that were paid through advance payments of the premium assistance subsidy. If you or a family member enrolled in a separate dental plan with pediatric benefits, this column includes the portion of the dental plan premiums for the pediatric benefits. If your plan covered benefits that are not essential health benefits, such as adult dental or vision benefits, the amount in this column will be reduced by the premiums for the nonessential benefits. If the policy was terminated by your insurance company due to nonpayment of premiums for one or more months, then a -0- will appear in this column for these months regardless of whether advance subsidy payments were made for these months.

Column (b). This column is the monthly premium for the second lowest cost silver plan (SLCSP) that the Marketplace has determined applies to members of your family enrolled in the coverage. The applicable SLCSP premium is used to compute your monthly advance subsidy payments and the premium assistance subsidy you take on your tax return. See the instructions for form FTB 3849, Part II, on how to use the information in this column or how to complete form FTB 3849 if there is no information entered. If the policy was terminated by your insurance company due to nonpayment of premiums for one or more months, then a -0- will appear in this column for the months, regardless of whether advance subsidy payments were made for these months.

Column (c). This column is the monthly amount of advance subsidy payments that were made to your insurance company on your behalf to pay for part of the premiums for your coverage. If this is the only column in Part II that is filled in with an amount other than zero for a month, it means your policy was terminated by your insurance company due to nonpayment of premiums, and you are not entitled to take the premium assistance subsidy for that month when you file your tax return. You still must reconcile the entire advance subsidy payment that was paid on your behalf for that month using form FTB 3849. No information will be entered in this column if no advance subsidy payments were made.

Taxable Year **2020**

California Health Insurance Marketplace Statement

California Form **3895**

☐ VOID ☐ CORRECTED

Recipient's name	Initial	Last Name	Suffix	Recipient's SSN	Recipient's date of birth
Enoch		Yannapu		155299763	10/12/1987
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Address (apt./ste, room, PO box, or PMB no.)
58 Wind Song

City(If you have a foreign address, see instructions.)	State	ZIP Code
Milpitas	CA	95035

Marketplace identifier	Marketplace-assigned policy number	Policy issuer's name
California	12671868	Kaiser
Policy start date	**Policy termination date**	☐ Repayment cap may not apply
02/01/2020	12/31/2020	

Part I Covered Individuals

	(a) Covered individual name		(b) Covered Individual SSN	(c) Covered individual date of birth	(d) Coverage start date	(e) Coverage termination date
	First name	Last name				
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13 August	$444.27	$444.27	0
14 September	$444.27	$444.27	0
15 October	$444.27	$444.27	0
16 November	$444.27	$444.27	0
17 December	$444.27	$444.27	0
18 **Annual Totals**	$4,886.97	$4,886.97	0

2020 Recipient Instructions for Form FTB 3895

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Frequently Asked Questions

Q: What is the California premium subsidy?

A: Beginning in 2020, Covered California offered a new type of financial help. The California premium subsidy lowers the premium (monthly cost) of a qualified health plan through Covered California. Covered California uses the information on your application to decide if you qualify.

Q: How does taking the California premium subsidy in advance (during the year) impact my taxes?

A: When you file state taxes at the end of the year, the Franchise Tax Board uses the final income and family size that you report on your state tax return to determine the amount of subsidy you were entitled to for the tax year. Based on your specific situation, **you may have to pay back some or all of the subsidy** you got during the year. Or you may qualify for more subsidy and get the rest as a refund. If you owe other state taxes, your unused subsidy may lower the amount you owe.

To help avoid having to pay back California premium subsidy next year, report any changes in income, family size, or eligibility for other health coverage, such as Medicare, Medi-Cal, or employer coverage to Covered California right away.

Q: Why am I getting Form FTB 3895?

A: We send Form FTB 3895 to everyone who got health insurance through Covered California in 2020. You need this form to file your state taxes. We also send Form FTB 3895 to the Franchise Tax Board. It shows:

- Who was enrolled and how many months they had health insurance
- How much was paid in monthly premiums
- How much California premium subsidy was paid to the health insurance company

Q: Why did I get more than one Form FTB 3895?

A: This could happen if members of your household were enrolled in different health plans. This could also happen if someone changed health plans or benefit levels during the year, such as changing from a Silver to a Gold plan.

Q: How do I use Form FTB 3895 to file my state taxes?

A: Use your Form FTB 3895 to fill out **Form FTB 3849, Premium Assistance Subsidy**. You must file this with your state tax return. You can get a blank copy on the Franchise Tax Board's website at www.ftb.ca.gov/forms/index.html. Your tax preparer or online tax service should also have the form.

Q: Why is there a -0- in Part III – Column A on my Form FTB 3895?

A: If you did not pay your premium (monthly cost) and your health plan ended, then a -0- will appear for each month you did not pay. This will happen even if you got the California premium subsidy (Part III – Column C) during those months.

Q: My Form FTB 3895 says I did not get any California premium subsidy during the year. Part III – Column C is blank or has all zeroes. Why?

A: This could happen if you did not apply for financial help or you did **not** qualify for the premium subsidy when you first applied. For example, your income did not meet the program rules, or you were eligible for other health insurance.

Q: Why do I need two different tax forms (Form FTB 3895 & IRS Form 1095-A) this year?

A: Starting in tax year 2020, both state **and** federal financial help are available through Covered California. These are reported on two different tax forms. Use Form FTB 3895 to report any state financial help you got and show proof of coverage when you file California state taxes. Use IRS Form 1095-A to report any federal financial help you got when you file federal taxes.

Q: Will I get a tax form for a family member who had other health insurance?

A: You may get IRS Form 1095-B or 1095-C if someone in your household had health insurance outside of Covered California. You can use these forms as proof of health insurance when you file your state taxes.

Note: The Department of Health Care Services (DHCS) will send IRS Form 1095-B to everyone who had Medi-Cal in 2020. You will get more than one form if some people in your family had Medi-Cal and others had Covered California. If you have questions, visit the DHCS website at http://dhcs.ca.gov/1095. Or call **1-844-253-0883**.

Section 1557 of the Patient Protection and Affordable Care Act (ACA)

Covered California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation. Covered California does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Covered California provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats and other formats). Covered California also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact the Civil Rights Coordinator at 1-916-228-8764 or by email at CivilRights@covered.ca.gov.

If you believe that Covered California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance with the Civil Rights Coordinator.

You can file a grievance in the following ways:

Mail: Civil Rights Coordinator
P.O. Box 989725
West Sacramento, CA 95798-9725

Phone: 1-916-228-8764

Fax: 1-916-228-8909

Email: CivilRights@covered.ca.gov

You can also file a civil rights complaint with the Office for Civil Rights at the U.S. Department of Health and Human Services.

Mail: U.S. Department of Health and Human Services
200 Independence Ave. SW, Room 509F, HHH Building
Washington, DC 20201

Phone: 1-800-368-1019 or TTY: 1-800-537-7697

Online: Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available on the U.S. Department of Health and Human Services Office for Civil Rights website.

Getting Help in a Language Other than English

IMPORTANT: Can you read this letter? You can call **1-800-300-1506** and ask for this letter translated to your language or in another format such as large print. For TTY call **1-888-889-4500** where you can also request this letter in alternate format.

Español IMPORTANTE: ¿Puede leer esta carta? Usted puede llamar al **1-800-300-0213** y pedir esta carta traducida en su idioma o en otro formato, como en letras grandes. Para TTY, llame al **1-888-889-4500**, donde también puede pedir esta carta en algún formato diferente. **(Spanish)**

中文/繁體字 重要事项：您能否阅读此信件？您可以致电 **1-800-300-1533,** 要求将此信件翻译为您的母语或者索要其他格式（如，大字版本）的信件。如需 TTY 服务或者索要其他格式的信件，请致电 **1-888-889-4500**。 **(Chinese)**

Tiếng Việt QUAN TRỌNG: Quý vị có thể đọc được bức thư này không? Quý vị có thể gọi điện đến số **1-800-652-9528** và yêu cầu được dịch bức thư này sang ngôn ngữ của quý vị hoặc chuyển sang định dạng khác như bản in khổ lớn. Người dùng TTY, hãy gọi số **1-888-889-4500** quý vị cũng có thể yêu cầu định dạng thay thế khác cho bức thư này. **(Vietnamese)**

한국어 중요: 이 편지를 읽을 수 있나요? **1-800-738-9116** 에 연락하셔서 번역되어 있거나 인쇄물 등 다른 포맷으로 되어 있는 편지를 요청해보세요. TTY **1-888-889-4500** 에서도 이 편지의 다른 포맷을 요청할 수도 있습니다. **(Korean)**

Tagalog MAHALAGA: Makakabasa ka ba sa sulat na ito? Maaari kang tumawag sa **1-800-983-8816** at humiling na isalin ang sulat na ito sa iyong wika o sa iba pang format katulad ng malalaking titik. Para sa TTY, tumawag sa **1-888-889-4500** kung saan maaari kang humiling ng alternatibong format ng sulat na ito.

العربية هام: هل يمكنك قراءة هذا الخطاب؟ يمكنك الاتصال بـ **1-800-826-6317** وطلب هذا الخطاب مترجمًا إلى لغتك أو بصيغة أخرى، بخط كبير مثلًا. للصم والبكم، اتصل بـ **1-888-889-4500** حيث يمكنك أيضاً أن تطلب هذا الخطاب بصيغة مختلفة. **(Arabic)**

հայերեն ԿԱՐԵՎՈՐ Է: Դուք կարո՞ղ եք կարդալ այս նամակը: Դուք կարող եք զանգահարել **1-800-996-1009** և խնդրել, որ այս նամակը թարգմանվի Ձեր լեզվով կամ Ձեզ տրվի մեկ այլ ձևաչափով, օրինակ՝ խոշորատառ: TTY-ի համար զանգահարեք **1-888-889-4500**, որտեղ կարող եք նաև այլընտրանքային ձևաչափով խնդրել այս նամակը: **(Armenian)**

ភាសាខ្មែរ សំខាន់ៈ តើលោកអ្នកអាចអានលិខិតនេះបានដែរឬទេ? លោកអ្នកអាចទូរស័ព្ទមកលេខ **1-800-906-8528** និងស្នើសុំឲ្យគេបកប្រែលិខិតនេះជាភាសារបស់លោកអ្នក ឬជាទម្រង់មួយផ្សេងទៀតដូចជាអក្សរពុម្ពធំៗ។ សម្រាប់ TTY ទូរស័ព្ទមកលេខ **1-888-889-4500** ដែលលោកអ្នកក៏អាចស្នើសុំលិខិតនេះ ជាទម្រង់ផ្សេងទៀត បានផងដែរ។ **(Khmer)**

Русский ВАЖНАЯ ИНФОРМАЦИЯ: Вы можете прочитать это письмо? Вы можете позвонить по телефону **1-800-778-7695** и запросить получение этого письма, переведенного на Ваш родной язык, или распечатанного крупным шрифтом. Лица со сниженным слухом могут позвонить по телефону **1-888-889-4500**, чтобы запросить это письмо в ином формате. **(Russian)**

فارسی مهم: آیا می توانید این نامه را بخوانید؟ می توانید با شماره **1-800-921-8879** تماس بگیرید و تقاضا کنید که این نامه به زبان شما ترجمه شود یا به فرمت دیگری مانند حروف درشت به شما ارسال شود. برای TTY با شماره **1-888-889-4500** تماس بگیرید و از طریق همان شماره همچنین می توانید درخواست کنید که این نامه به فرمت دیگری به شما ارسال شود. **(Farsi)**

Hmoob TSEEM CEEB: Koj nyeem puas tau tsab ntawv no? Koj hu tau rau **1-800-771-2156** nug daim ntawv txais ua yog koj cov lus los yog lwm hom xws lis tus ntawv loj. Hu tau TTY ntawm **1-800-889-4500** ua koj thov hloov tau lwm hom. **(Hmong)**

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? इस पत्र को अपनी भाषा में अनुवाद करने के लिए या बड़े प्रिंट की तरह किसी अन्य प्रारूप में प्राप्त करने के लिए **1-800-300-1506** पर कॉल करके अनुरोध कर सकते हैं। TTY के लिए **1-888-889-4500** पर कॉल करें जहाँ आप इस पत्र को किसी अन्य प्रारूप में प्राप्त करने का अनुरोध कर सकते हैं। **(Hindi)**

重要：この文書を読むことができますか？希望の言語に翻訳された文書、または大きな文字など別の形式の文書をご希望の場合、1-800-300-1506 までお電話ください。TTY の場合、**1-888-889-4500 にお電話いただければ、その他の形式の文書をリクエストすることもできます。(Japanese)**

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ ਸਕਦੇ ਹੋ ਤੁਸੀਂ **1-800-300-1506** 'ਤੇ ਕਾਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਇਸ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਜਾਂ ਕਿਸੇ ਹੋਰ ਸਰੂਪ ਵਿਚ, ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਪਰਿੰਟ ਲਈ ਪੁੱਛ ਸਕਦੇ ਹੋ। ਟੀਟੀਵਾਇ ਲਈ **1-888-889-4500** 'ਤੇ ਕਲ ਕਰੋ ਜਿੱਥੇ ਕਿ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਦੇ ਵਿਕਲਪਕ ਰੂਪ ਵਿਚ ਸਰੂਪ ਲਈ ਬੇਨਤੀ ਵੀ ਕਰ ਸਕਦੇ ਹੋ। **(Punjabi)**

สำคัญ: คุณสามารถอ่านจดหมายฉบับนี้ได้หรือไม่? ถ้าคุณมีข้อสงสัย คุณสามารถติดต่อได้ที่เบอร์ **1-800-300-1506** เพื่อทำการพูดคุยกับเจ้าหน้าที่ที่ใช้ภาษาของคุณ นอกจากนี้คุณยังสามารถร้องขอให้แปลจดหมายฉบับนี้เป็นภาษาที่คุณต้อง การได้หรือเปลี่ยนแปลงรูปแบบตัวอักษรให้เป็ นรูปแบบอื่น เช่น ตัวอักษรพิมพ์ใหญ่หรือทำให้มีขนาดใหญ่ขึ้น สำหรับระบบ TTY คุณสามารถติดต่อได้ที่เบอร์ **1-888-889-4500** ซึ่งคุณสามารถขอจดหมายฉบับนี้ในรูปแบบอื่น ๆ ได้ตามที่คุณต้องการ **(Thai)**