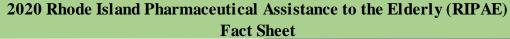
Rosamaria Amoros Jones Director









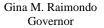
## Who Qualifies:

The Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE) Program pays a portion of the cost of RIPAE approved medications purchased during the deductible stage of your Part D plan. RI residents who are 65 years and older can have access to Level 1 thru 3, ranging from 15%, 30% or 60% help in that stage. Level four is for the individuals that are age 55 to 64 who get a 15% discount only during the deductible stage of the Part D only.

	Quali	ifying Levels:		
Age 65 and older	Single Person	Married Couple	State Share	Member Share
1 (8018)	\$0 to \$23,968	\$0 to \$29,963	60%	40%
2 (8019)	\$23,968 to \$30,089	\$29,963 to \$37,625	30%	70%
3 (8020)	\$30,089 to \$52,755	\$37,625 to \$60,179	15%	85%
Age 55 to 64				
4 (8021)	\$0 to \$52,755	\$0 to \$60,179	15%	85%

- \* Due to an increase of SS benefits for the year of 2020 the income guideline was adjusted by 1.6%
- \* You may qualify for a one (1) time only Special Enrollment Period (SEP) if you are on RIPAE at any level during the regular calendar year
- \* You must be enrolled into a Part D plan
- \* You must provide proof of all your income
- \* You must provide proof you are a RI resident
- \* You must notify OHA in writing with any address change within 10 to 14 days of moving

Health Aging



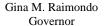
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\*Please Review Both Sides of Application

## **RIPAE Application Required Documentation**

ш	An	y One of the following to Document Age:
	0	RI Driver's License
	0	RI Identification Card
	0	Birth Certificate
	0	Pharmacy Printout with Date-Of-Birth Imprint
	A (	Copy of your Medicare Part D Card
	Α (	Copy of Any and All Income for 2019. Any listing or verification from an agency or
		anization from below shall constitute acceptable documentation of Income:
	0	Federal Income Tax Return
	0	Social Security Income Document (Award Letter)
	0	Employment Income: W-2 Form, pay stubs with year to date total
	0	TDI/Worker's Compensation
	0	Unemployment Benefits
	0	Alimony or Support
	0	Pension Benefits (Veterans Benefits, etc.) a current or previous year's award letter
	0	TANF (Temporary Aid to Needy Families) /GPA (General Public Assistance)
	0	Interest Income
	0	W-9 Interest Form
	0	Rental Income
	0	Self-Employment Income
	An	y one of the following to Document Residency:
	0	RI Driver's License
	0	RI Identification Card
	0	Vehicle Registration
	0	Any other Official Document which indicates applicants' permanent residence.
	A (	Copy of your Medicare Card
	A (	Copy of your Social Security Card
	The	e Completed RIPAE Application Package



Rosamaria Amoros Jones Director



## RIPAE APPLICATION

Please print clearly; (\*) means required information

*Last Name	*First !	Name	Middle Initi	al
*Gender: Male Female Divorced	e	*Marital Status: Single_	Married	Widowed_
*Resident Address (Street,	PO Box, or Route N	Number)		
*Apt # (if applicable)		*State		_
*Telephone #	*Applicant's	Own Social Security Nu	ımber#	
*Date of Birth (Month, Day	y, Year):			
*Do you have prescription		,		
*Plan Name*  *Medicare Part D Plan ID				
Please Circle One:				
1. Are you a Veteran? Yes	or No <b>2. Are you</b>	<b>Disabled?</b> Yes or No		
Race/Ethnicity (optional):				
White Black Nativ	e American His	panic Asian Oth	ner No Respo	onse
Type of Residence (optiona	d):			
Community Subsidized	Housing Assis	ated Living Nursing I	Home/Res. Care	Other



Gina M. Raimondo Governor

Rosamaria Amoros Jones Director

## **CERTIFICATE AND AUTHORIZATION:**

- 1. I authorize The Office of Healthy Aging (OHA) to verify information on this application by contacting employers and/or appropriate agencies.
- 2. I authorize OHA to visit my residence, with reasonable prior notice to me, for the purpose of validating the information provided on this application, or any claims made under application for RIPAE.
- 3. I hereby waive confidentiality of information found in any third-party insurer's file, as witnessed by my signature on this application.
- 4. I understand that any person who submits a false or fraudulent RIPAE claim, who aids and abets another in submission of a false or fraudulent claim, or who claims and receives duplicate benefits is punishable and may be subject to prosecution under the provisions of RIPAE law. Any person who is found guilty of intentionally violating RIPAE program provisions shall be subject to immediate termination from the program for a period of not less than one (1) year.
- 5. I understand that all OHA actions against the applicant which relate to the application process are subject to the right of appeal in accordance with the provisions of Chapter 42-66.2 of the State of Rhode Island General Laws.
- 6. I understand that if I am enrolled into the State Medicaid program, I am no longer eligible for the RIPAE program and will be removed.
- 7. BY SIGNING, I ACKNOWLEDGE THAT I HAVE READ THE APPLICATION AND AUTHORIZATION AND AGREE TO THE TERMS AS STATED.

Applicant's Signature:	Date:	Tel:
Preparer's Signature:	_ Date:	_Tel:
OHA Reviewer's Signature:	_ Date:	Tel:



Gina M. Raimondo Governor

Rosamaria Amoros Jones Director

IF YOU NEED ASSISTANCE WITH COMPLETING THIS RIPAE APPLICATION PLEASE CONTACT THE BENEFITS ENROLLMENT COUNSELOR WENDY HEUGAS AT 401-444-0659.

IF YOU HAVE TROUBLE UNDERSTANDING THIS FORM, PLEASE CALL OHA AT 401-462-3000. TTY USERS CAN CALL RI Relay via 711.

SI-USTED PROBLEMAS PARAENTENDER ESTE FOMULARIO, POR FAROR LLAMEA OHA, 401-462-3000. (TTY USERS CAN CALL RI Relay via 711).

SI VOCE TEM PROBLEMAS A COMPRENDER ESTA FORMULARIO, POR FAVOR CHAMA OHA A 401-462-3000. (TTY USERS CAN CALL RI Relay via 711).

\*When submitting a RIPAE Application you must ensure that you include ALL required documentation with the submission. If you fail to submit all the required documentation your application will be considered incomplete and will not be processed. All forms and documentation must be sent to:

R.I. Office of Healthy Aging Attn: Kim Timpson Louis Pasteur Building 57 Howard Avenue Cranston, RI 02920

For OHA Use Only:		
Age verification (Source)		<del>_</del>
Address verification (Source)		_
Federal tax return Tax	x return year	
Bank statement (Name of bank)	Statement dated	_
Pension benefit (Source)	Statement dated	_
IRA distribution (Source)	Statement dated	
Total countable income	Part D enrollment: Y	_ No
"Extra Help" letter submitted? Yes No		
RIPAE Eligibility Group#: RD8018 RD8019	RD8020 RD8021	RL8018
PBM USE ONLY: Received: Entered: (	Checked By: Date:	