RHODE ISLAND OFFICE OF HealthyAging

Gina M. Raimondo
Governor

Rosamaria Amoros Jones
Director

2020 Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE) Fact Sheet

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.

Qualifying 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**

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*Please Review Both Sides of Application

RIPAE Application Required Documentation

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

Office of Health Aging
25 Howard Ave, Louis Pasteur Bldg. #57
Cranston, RI 02920
Telephone: (401) 462-3000 Fax: 401-462-0503
TTY via RI Relay 711 Web Site: www.oha.ri.gov

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RIPAE APPLICATION

Please print clearly; (*) means required information

***Last Name**_____ ***First Name**_____ **Middle Initial**_____

***Gender**: Male____ Female_____ Other_____ ***Marital Status:** Single____ Married_____ Widowed_____ Divorced_____

***Resident Address (Street, PO Box, or Route Number)**

_____

***Apt # (if applicable)** _____ ***City**_____ ***State**_____ ***Zip Code**_____

***Telephone #**_____ *Applicant's **Own** Social Security Number# _____

***Date of Birth (Month, Day, Year):** _____

***Do you have prescription drug coverage? (Medicare Part D)** Yes _____ No_____

***Plan Name**_____

***Medicare Part D Plan ID #**_____ ***Medicare ID #**_____

Please Circle One:

1. Are you a Veteran? Yes or No **2. Are you Disabled?** Yes or No

Race/Ethnicity (optional):

White____ Black____ Native American____ Hispanic____ Asian____ Other____ No Response ____

Type of Residence (optional):

Community____ Subsidized Housing_____ Assisted Living____ Nursing Home/Res. Care_____ Other____

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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: _____

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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

************************************STOP DO NOT FILL OUT***************************************

For OHA Use Only:

Age verification (Source) _____
Address verification (Source) _____
Federal tax return_____ State tax return_____ Tax 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: _____

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