RHODE ISLAND OFFICE OF HealthyAging

Daniel J McKee
Governor

Michelle Szylin
Interim Director

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 Check:

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

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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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 POINT AT 401-462-4444.

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
25 Howard Ave, Louis Pasteur Bldg. #57
Cranston, RI 02920

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

For OHA Use Only: New Application Change of Status Application

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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RIPAE Application Required Documentation

***Please Note: All required documentation must be a copy and not the original document. These documents will not be returned.**

Any One of the following to Document Age:	○ RI Driver's License ○ RI Identification Card ○ Birth Certificate ○ Pharmacy Printout with Date-Of-Birth Imprint
Proof of Medicare Part D plan	○ Must supply a copy of plan card
A Copy of Any and All Income for 2020. Any listing or verification from an agency or organization from right side shall constitute acceptable documentation of Income: **If your income falls below:** $19,140 income/ 14,790 resources for an individual or $25,860 income/29,520 resources for a married couple living together You must apply for Extra Help thru Social Security Administration (SSA)	○ 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 in Rhode Island	○ RI Driver's License ○ RI Identification Card ○ Vehicle Registration ○ Any other Official Document which indicates applicants' permanent residence.
Medicare Card	○ Must supply a copy to verify eligibility
Social Security Card	○ Must supply a copy to verify identity

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