

# 2025 Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE) Fact Sheet





#### Who Qualifies:

The Rhode Island Pharmaceutical Assistance to Elders (RIPAE) Program pays a portion of the cost of RIPAE-approved medications purchased during the Deductible stage of a Part D plan and will help if an individual's Part D plan does not cover a medication, provided it is an approved medication on the formulary. Annual income(s) determine which level of the program individuals are enrolled.

Qualifying Levels				
65 and older	Single Individual	Married Couple	State Share	Member Share
Level 1	Less than \$37,940	Less than \$48,948	60%	40%
Level 2	\$37,940-\$47,631	\$48,948 -\$59,559	30%	70%
Level 3	\$47,631 – \$83,510	\$59,559 – \$95,261	15%	85%
Level 4 (Ages 55- 64)	= to or less than \$83,510		15%	85%

<sup>\*</sup> Income guidelines were adjusted with a 2.5% increase effective 1-1-2025

### **Additional Qualifications:**

- You must be enrolled in a Medicare Part D plan
- You can not be enrolled in SSA-LIS or Medicaid
- You must prove you are a Rhode Island resident

#### **Additional Benefits:**

- For any RIPAE level, you will qualify for a one (1) time Special Enrollment Period (SEP) during a calendar year
- If you are eligible for Level 1, you will have free access to any Rhode Island state beach Submit completed RIPAE applications and required supporting documentation to the below address. For any questions contact RI Office of Healthy Aging at 401-462-3000.

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





## RIPAE APPLICATION

Please print clearly. (*) means re-	quired information N	ew Redete	ermination	
*Last Name	*First Name	irst Name		al
*Gender: Male Female Divorced	Other* <b>Mari</b> t	ral Status: Single_	Married	Widowed
Resident Address (Street, PO)	Box, or Route Numbe	er)		
Apt # (if applicable)				-
*Telephone #	*Applicant's Own	Social Security N	umber#	
Date of Birth (Month, Day, Ye	ar):			
Do you have prescription drug	coverage? (Medicare	e Part D) Yes	No	
Plan Name				
Medicare Part D Plan ID #		*Medicare ID	) #	
Please Circle Check:				
. Are you a Veteran? Yes	No <b>2.</b> Ar	e you Disabled? Y	es No	
Race/Ethnicity (optional):				
White Black Native An	nerican Hispanic_	Asian Otl	ner No Respo	nse
Гуре of Residence (optional):				
Community Subsidized Hou	sino Assisted I i	vino Nursino	Home/Res Care	Other



Daniel McKee

Governor

Maria Cimini

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:	
<b>OHA Reviewer's Signature:</b>	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: RIPAE Program Louis Pasteur Building 57 Howard Avenue Cranston, RI 02920

For OHA Use Only:				
Age verification (Source)				_
Address verification (Source)				_
Federal tax return State tax retu	ırn Ta	x return year		
Bank statement (Name of bank)		Statement da	ited	
Pension benefit (Source)		Statement da	ated	
IRA distribution (Source)		Statement da	ited	
Total countable income		Part D enrol	lment: Y	_ No
"Extra Help" letter submitted? Yes	No	<del></del>		
DDAF E1: '1'1'4 C	<b>DD</b> 0010	BD0020	DD0021	DI 0010
RIPAE Eligibility Group#: RD8018	_RD8019	RD8020	RD8021	RL8018
PBM USE ONLY: Received: E	ntered:	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:	o RI Driver's License
	<ul> <li>RI Identification Card</li> </ul>
	<ul> <li>Birth Certificate</li> </ul>
	<ul> <li>Pharmacy Printout with Date-Of-Birth</li> </ul>
	Imprint
Proof of Medicare Part D plan	<ul> <li>Must supply a copy of plan card</li> </ul>
A Copy of Any and All Income. Any listing or verification	Federal Income Tax Return
from an agency or organization from right side shall	<ul> <li>Social Security Income Document</li> </ul>
constitute acceptable documentation of Income:	(Award Letter)
·	<ul> <li>Employment Income: W-2 Form, pay</li> </ul>
If your income falls below:	stubs with year-to-date total
•	<ul> <li>TDI/Worker's Compensation</li> </ul>
Single: \$22,590 income/ \$17,600 resources	<ul> <li>Unemployment Benefits</li> </ul>
	<ul> <li>Alimony or Support</li> </ul>
Married: \$30,660 income/ \$35,130 resources	<ul> <li>Pension Benefits (Veterans Benefits,</li> </ul>
	etc.) a current or previous year's award
You must apply for Extra Help through Social	letter
Security Administration (SSA).	<ul> <li>TANF (Temporary Aid to Needy Families)</li> </ul>
	/GPA (General Public Assistance)
	o Interest Income
	<ul> <li>W-9 Interest Form</li> </ul>
	o Rental Income
	<ul> <li>Self-Employment Income</li> </ul>
	, ,
Any one of the following to Document Residency in	o RI Driver's License
Rhode Island	<ul> <li>RI Identification Card</li> </ul>
	<ul> <li>Vehicle Registration</li> </ul>
	<ul> <li>Any other Official Document which</li> </ul>
	indicates applicants' permanent
	residence.
Medicare Card	Must supply a copy to verify eligibility
Social Security Card	Must supply a copy to verify identity