



Daniel McKee
Governor
Maria Cimini
Director

RIPAE APPLICATION

Please print clearly. (*) means required information New _____ Redetermination _____

*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 ___



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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 PARA ENTENDER ESTE FORMULARIO, POR FAVOR LLAME A OHA, 401-462-3000. (TTY USERS CAN CALL RI Relay via 711).

SI VOCE TEM PROBLEMAS A COMPRENDER ESTE 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
 25 Howard Ave, Building 57
 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: _____

Office of Healthy 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 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:	<ul style="list-style-type: none"> ○ RI Driver's License ○ RI Identification Card ○ Birth Certificate ○ Pharmacy Printout with Date-Of-Birth Imprint
Proof of Medicare Part D plan	<ul style="list-style-type: none"> ○ Must supply a copy of plan card
<p>A Copy of Any and All Income. Any listing or verification from an agency or organization from right side shall constitute acceptable documentation of Income:</p> <p>*Please note: If your income falls below the following income/resource limits you must apply for Social Security's Extra Help Program:</p> <p>Single: \$24,180 income/ \$16,590 resources Married: \$32,700 income/\$33,100resources</p>	<ul style="list-style-type: none"> ○ 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	<ul style="list-style-type: none"> ○ RI Driver's License ○ RI Identification Card ○ Vehicle Registration ○ Any other Official Document which indicates applicants' permanent residence.
Medicare Card	<ul style="list-style-type: none"> ○ Must supply a copy to verify eligibility
Social Security Card	<ul style="list-style-type: none"> ○ Must supply a copy to verify identity