RHODE ISLAND OFFICE OF HealthyAging

Rhode Island Pharmaceutical Assistance to Elders (RIPAE) Program Application

Contact Information

Name (First & Last): _____

Address: _____

City/Town: _____ State: _____ Zip Code: _____

Mailing Address (If different from Physical Address)

Address: _____

City/Town: _____ State: _____ Zip Code: _____

Primary Phone Number : _____ Other Phone Number: _____

About You

Social Security Number: _____ Date of Birth: _____

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

Do you have a Medicare Part D plan or a Medicare Advantage Plan? Yes _____ No _____

Medicare Plan Name: _____ Medicare Plan ID Number: _____

Medicare Number: _____

Total Gross Monthly Income: $_____

About Your Spouse (Complete ONLY if Spouse is Applying)

Spouse's Name (First & Last): _____

Spouse's Social Security Number: _____ Spouse's Date of Birth: _____

Do you have a Medicare Part D plan or a Medicare Advantage Plan? Yes _____ No _____

Medicare Plan Name: _____ Medicare Plan ID Number: _____

Medicare Number: _____

Total Gross Monthly Income: $_____

***IF MARRIED, PLEASE SUBMIT ALL INCOME DOCUMENTATION FOR BOTH APPLICANT AND SPOUSE.**

******REFER TO RIPAE APPLICATION REQUIRED DOCUMENTS ON LAST PAGE*******

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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.

BY SIGNING, I ACKNOWLEDGE THAT I HAVE READ THE APPLICATION AND AUTHORIZATION AND AGREE TO THE TERMS AS STATED.

Applicant's Signature: _____ **Date:** _____

Spouse's Signature: _____ **Date:** _____

OHA Reviewer's Signature: _____ **Date:** _____

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If you have trouble understanding this application, need assistance with completing, or looking for more information regarding the RIPAE program, please contact the

State Health Insurance Assistance Program (SHIP) at – 1-888-884-8721.

****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:**

Rhode Island Office of Healthy Aging
Attn: RIPAE Program
Louis Pasteur Building
25 Howard Ave, Building 57
Cranston, RI 02920

****************************STOP DO NOT COMPLETE BELOW***************************

For OHA Use Only:

Age Verification Documentation _____

Residency Verification Documentation _____

Social Security Verification Documentation _____

Medicare Verification Documentation _____

Medicare Plan Verification Documentation _____

Income Verification Documentation _____

Total Countable Income $_____

Verified in CMS MARx Part D or Medicare Advantage Enrollment: Yes____ No_____

Verified in CMS MARx Applicant has Extra Help: Yes____ No_____

Verified in DHS Bridges Applicant has Medicaid: Yes____ No____

RIPAE Eligibility Group #: RD8018_____ RD8019_____ RD8020 _____ RD8021_____ RL8018_____

PBM USE ONLY: Received: _____ **Entered:** _____ **Checked By:** _____ **Date:** _____

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Age Verification	• RI Driver's License • RI Identification Card • Birth Certificate • Passport • Any other Official Document which indicates applicant's age.
Residency Verification	• RI Driver's License • RI Identification Card • Passport • Vehicle Registration • Any other Official Document which indicates applicant's permanent residence.
Social Security Verification	• Social Security Card • Any other Official Document which indicates applicant's social security number.
Medicare Verification	• Medicare Card (red, white & blue card) • Any other Official Document which indicates applicant's Medicare number.
Medicare Plan Verification	• Medicare Part D Prescription plan or Medicare Advantage Plan member Card
Income Verification A Copy of Any and All Income. If married, please submit **ALL** income for **BOTH** applicant and spouse even if only one person is applying. Any listing or verification from an agency or organization from right side shall constitute acceptable documentation of Income: ***Please note: If your income falls below the following income/resource limits you must apply for Social Security's Extra Help Program:** **Single:** $24,180 income/ $16,590 resources **Married:** $32,700 income/$33,100 resources You can apply for the Social Security Extra Help Application at: https://www.ssa.gov/medicare/part-d-extra-help	• 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