STATE OF RHODE ISLAND
P.O. BOX 8709
CRANSTON, RI 02920-8787

Date : 05/01/2023
Case Number : [redacted]
Document# : [redacted]

DBDFXNUNG BGPFBJNAD AEAGSYZKE
49 Dtuo St
Smithfield, RI 02828

How to Contact Us
Go Online: https://healthyrhode.ri.gov

For questions about affordable health coverage or human services programs, call Department of Human Services at 1-855-MY-RI-DHS (1-855-697-4347)

State of Rhode Island

MEDICAID LONG-TERM SERVICE AND SUPPORTS RENEWAL

(Katie Beckett Eligibility, Home and Community-based Services for Elders and Adults with Disabilities, Nursing facilities, BHDDH and PACE)

Review the Information We Have on File for You

The people listed below will be automatically renewed for Medicaid

Program Name	Name	Date current benefit will get renewed
Medicaid	[redacted]	07/01/2023

How will my Medicaid health coverage be renewed?

This form has the information about your household we used to decide your eligibility. Please review the entire form to make sure the information is still correct.

- **If there are no changes, DO NOTHING:** If all the information on this form is still correct, your Medicaid health coverage will be automatically renewed for another year. We will send you another letter letting you know your Medicaid health coverage is continued before the renewal date.

- **If there are changes, REPORT THEM:** If you are reporting changes, please complete and return this form to report changes. We will review the information you give us and decide if you are eligible to renew your Medicaid health coverage. We will send you another letter letting you know what we decide or if we need more information before the renewal date.

- **If you were asked to provide additional documents** or you reported changes, we will review the information you give us and decide if you are eligible to renew your Medicaid health coverage. We will send you another letter letting you know what we decide or if we need more information before the renewal date.

For more information visit https://healthyrhode.ri.gov
Para más información visite https://healthyrhode.ri.gov
Para mais informações visite https://healthyrhode.ri.gov

What changes do I need to report?

- **Income**: We need to know about any changes in the income of the LTSS beneficiary and any spouse or dependents who are considered when determining the amount that must be paid toward the cost of care each month. If this renewal is for a Katie Beckett eligible child, we only need to know the income of the child. There is no required contribution toward the cost of care.

- **Resources**: We also need to know if the resources of the LTSS beneficiary have increased and/or if any resources the beneficiary owns outright or jointly have been sold or transferred to someone else.

- **Address and living arrangement**: Tell us if the LTSS beneficiary has moved or changed addresses, entered or left an assisted living residence, nursing facility or group home, or is in a new or different shared living arrangement.

- **Home Owner intent to return to primary residence:** FOR NURSING FACILITY RESIDENTS ONLY: if you own a home that is your primary residence, we assume you intend to return to live in this real estate at an appropriate time in the future, If there are changes to your ownership or intent to return to this residence, please update section 5 below.

- **Family and household circumstances**: We need to know if there have been changes in the household of the beneficiary such as if the spouse or a dependent of an LTSS beneficiary has died, received a divorce, married someone else, or moved into, out of, or sold a house that is NOT counted as a resource. This information is not required for renewal of a Katie Beckett eligible child.

- **Immigration status**: You must tell us if the immigration status of a non-citizen LTSS beneficiary and/or a sponsor has changed since the date of the initial application or last renewal.

How can I report my changes and renew my Medicaid coverage?

There are several ways to report changes. Please read the following directions carefully.

- **Mail:** If you choose to reply by mail, please write the information that has changed in the "Updated Information" column of this notice. IF NO INFORMATION IS PREPRINTED AND YOU ARE RETURNING THIS FORM, FILL IN THE BOXES WITH "CURRENT INFORMATION". Please be sure to sign and date the form. The form can be mailed to the address at the top of this notice. Katie Beckett eligible children should send the form to DHS-LTSS P.O. BOX 8709 CRANSTON, RI 02920

- **Drop off at a DHS Office:** If you choose to drop off the form at a DHS office, please follow the instructions listed above for Mail. For office locations, visit **www.dhs.ri.gov** or call 1-855-MY-RI-DHS (1-855-697-4347).

- **Online:** You can also go to your User Account on https://healthyrhode.ri.gov and make the changes.

View Your Account Online

Your benefit information is also available by logging into your account at **https://healthyrhode.ri.gov/**.
You can access your account using username [redacted]. If you don't remember your password, you can retrieve it by clicking LOG IN then clicking Forgot Username/Password? at **https://healthyrhode.ri.gov/**. Through your account, you can apply for and renew your benefits and report changes.

For more information visit https://healthyrhode.ri.gov
Para más información visite https://healthyrhode.ri.gov
Para mais informações visite https://healthyrhode.ri.gov

Case #: [redacted]

LTSS Renewal Form

Directions: Please carefully read this form and write-in changed information about the beneficiary. If you're reporting changes, be sure to return the entire renewal form, including this page.

Beneficiary's Contact Information

	Current Information	Updated Information
Primary Contact and Relationship to Beneficiary	[redacted]	
Mailing Address	[redacted]	
	Current Information	Updated Information
Address where LTSS Beneficiary Lives now	[redacted]	
	Current Information	Updated Information
Phone Number	[redacted]	
Email		
Name of Authorized Representative	Current Information	Updated Information
	[redacted]	

1. Income:

Since the beneficiary initially applied or was last renewed, have there been any changes to income? We need to know about any changes in the income of the beneficiary. We also need to know the names and income of any spouse and dependents we must consider when determining the amount adult LTSS beneficiaries must pay toward the cost of care.

If the boxes are blank, please provide the requested information.

If the boxes are preprinted, cross out information that is wrong and provide the correct information in the empty rows below. Add the names and income of any new dependents.

Send proof of new or corrected amounts of income with this form.

Note: For Katie Beckett eligible children, please include the income of the child only.

☐ Check if NO changes in income to report

Case #: [redacted]

Name	SSN	DOB	Relationship to LTSS Beneficiary	Income/ Type
[redacted]	XXX-XX-[redacted]	[redacted]	Self	$ 582.56/ Employment

2. Resources

Since the LTSS beneficiary initially applied or was last renewed, have there been any changes in the resources the beneficiary owns, including any increases or decreases? If the LTSS beneficiary has any new or changed resources (sold or transferred), please list them below under "current information". If the form is preprinted, cross out information that is wrong and provide the correct updated information in the boxes on the right.

NOTE: RESOURCES INCLUDE CASH ON HAND, SAVINGS AND CHECKING ACCOUNTS, CERTIFICATES OF DEPOSIT, STOCK, BONDS, ABLE ACCOUNTS, TRUST FUNDS, OWNERSHIP OF A BUSINESS, ETC.

☐ Check if NO changes in resources to report.

Owner name	Resources	Current Information	Updated Information
	Vehicle(s)	-	
	Checking/Savings	-	
	Stocks/bonds	-	
	Certificates of Deposit	-	
	Money Market Accounts	-	
	Ownership of a Business	-	
	Annuities	-	
	IRA, 401K, 403B, Keogh Accounts	-	
	Burial Contracts or Accounts	-	
	Other	-	

2a. **Trusts**

If the LTSS beneficiary or someone acting on behalf of the beneficiary established or transferred any item of value such as an inheritance, property, insurance settlement, IRA distribution, burial contract, stock portfolio, trust fund, annuity plan, brokerage account, insurance settlement, or the like into a trust within the last sixty (60) months, fill-in the boxes below and send in proof.

☐ Check if NO trust activities to report.

Describe the item	Date of Action	Value/Amount of item placed in Trust

3. Real Estate, including home of the LTSS Beneficiary

Has there been any change in the beneficiary's ownership interest in real estate/property (like a house or land) since the time of initial application or last renewal? Fill in the blanks or correct any wrong information in the boxes below and send us documentation of changes related to sales, transfers, and income.

☐ NO real Estate/property changes to report.

Real Estate and Other Property		
1. Primary Residence	Current Information	Updated Information
	-	
Spouses/Dependents live in house	Current Information	Updated Information
	-	
Income from Property - rent or lease	Current Information	Updated Information
	-	
Sale/Transfer Date	Current Information	Updated Information
	-	

2. Other Property/Residence (address)	Current Information	Updated Information
	-	
Equity Value - Worth less any liens, debts, loans	Current Information	Updated Information
	-	
Income from Property - rent or lease	Current Information	Updated Information
	-	
Sale/Transfer Date	Current Information	Updated Information
	-	

4. Health Insurance Coverage

Provide complete and up-to-date information about all forms of health insurance that provide coverage to the beneficiary by filling in the blanks or correcting the preprinted information in empty boxes in the row below. Include employer, retiree, and other private health plans; dental, vision and other supplemental plans; and Medicare, Tricare, and similar government plans.

Please send copies of the front and back of all new and updated health insurance cards for these plans.

☐ Check if NO changes in health insurance coverage to report

Health Insurance	Policy Holder's Name	Policy Number	Monthly Premium

Section 5: FOR NURSING FACILITY RESIDENTS ONLY

INTENT TO RETURN TO PRIMARY RESIDENCE

Complete ONLY if you are currently residing in a nursing facility and own a home.

I,_____, hereby certify that I own the real estate located

(Name of Applicant/Beneficiary)

at _____ _____-__

(Street Address) (City) (State and Zip Code)

Further, I certify that this real estate is my principal residence;

I own the above listed real estate: (Please Check One)

☐ Solely ☐ Jointly

☐ Tenants in common ☐ Life Estate

I understand and agree that it is my responsibility to inform the DHS (within ten (10) days) of any change in my ownership of this real estate. I also agree to inform the DHS of any change in my intent to return to live in the above listed real estate.therefore, I am reporting the following changes: (write below to indicate changes)

_____
_____
_____
_____.

PENALTY WARNING		
"Under penalties of perjury, I swear that this renewal form has been examined by or read to me, and, to the best of my knowledge, the facts are true and complete. If I am applying on behalf of another person, I swear that this application has been examined by or read to the applicant, and, to the best of his/her knowledge, the facts are true and complete."		
Signature of Client or Authorized Representative Date:		
Signature of Spouse or parent Date:		
Signature of Guardian/Conservator/Holder of power of attorney Date:	Signature of Department Witness Date:	
Telephone Number	( )	

YOUR CONSENT TO SHARE DATA FOR ELIGIBILITY DECISIONS

We can help you better if we are able to work with other agencies and professionals that know you and your family. By checking the "I Agree" box, you are giving permission for us to obtain, use and share confidential information about you from a variety of sources including the R.I. Department of Labor and Training, the R.I. Department of Human Services, the R.I. Executive Office of Health and Human Services, the R.I. Department of Health, the R.I. Department of Corrections, and Experian on behalf of Centers for Medicaid and Medicare Services (CMS) and the Social Security Administration.

We will not refuse you any benefits or access to any programs for which you are eligible simply because you do not give us permission to obtain, use and share confidential information. However, without your consent, we are unable to assist you in accessing certain programs and supports for which you may be eligible. Your consent is required in order to determine your eligibility.

You can proceed to shop for and purchase health insurance coverage without completing this consent by contacting our Contact Center at 1-855-840-HSRI (4774), but if you would like to know whether you are eligible for any financial help for the purchase of coverage, whether you are eligible for Medicaid, it will be necessary for you to complete this consent.

All information sharing and use that you are authorizing by checking the "I Agree" box will be done in compliance with all relevant federal and state laws and regulations protecting your privacy, including but not limited to: The Health Insurance Portability and Accounting Act of 1996 (Pub. L. 104-191 known as HIPAA); The R.I. Confidentiality of Health Care Communications and Information (R.I.G.L. 5-37.3-1 et seq.); R.I.G.L. 28-32-5, 28-36-12, 28-42-38, 28-39-19, 28-39-22, 40.1-5-26, 23-3-23, 42-12-22, 40-6-12 and all other applicable laws and regulations. Information will be shared by computer data transfer.

By checking on the first box below, I consent to the obtaining and use of confidential information about me to determine my eligibility for enrollment in publicly funded health insurance coverage or other publicly funded programs administered through this site, plan, provide, and coordinate benefits and payments.

- ☐ I give my consent to share data for eligibility decisions
- ☐ I do *not* give my consent and understand that my eligibility for certain programs and supports will be affected by this decision

You have a RIGHT to non-discriminatory treatment. In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the responsible Agency or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at **https://www.usda.gov/sites/default/files/documents/usda-program-discrimination-complaint-form.pdf** and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: **program.intake@usda.gov**. USDA is an equal opportunity provider, employer, and lender.

In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), and Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Food and Nutrition Act of 2008 (formerly the Food Stamp Act), the Age Discrimination Act of 1975, the U.S. Department of Health and Human Services implementing regulations (45 C.F.R. Parts 80 and 84) and the U.S. Department of Education implementing regulations (34 C.F.R. Parts 104 and 106), and the U.S. Department of Agriculture, Food and Nutrition Services (7 C.F.R. 272.6); the Executive Office of Health and Human Services (EOHHS) and the Department of Human Services (DHS), do not discriminate on the basis of race, color, national origin, disability, religion, political beliefs, age or gender in acceptance for or provision of services, employment or treatment, in its education and other program activities. Under other provisions of applicable law, EOHHS and DHS do not discriminate on the basis of sexual orientation, gender identity or expression. For further information about these non-discrimination laws, regulations and complaint procedures for resolution of complaints of discrimination, contact DHS at 25 Howard Ave, Bldg. 57, Cranston, RI 02920 (401) 462-2971. To place a call using Rhode Island Relay, dial 7-1-1 or call one of these toll free numbers: TTY: 1-800-745-5555, Voice: 1-800-745-6575. The Community Relations Liaison Officer is the coordinator for implementation of Title VI, the Office of Rehabilitation Services (ORS) Administrator or his/her designee is the coordinator for implementation of the Title IX, Section 504, and ADA. The Director of DHS or his/her designee has the overall responsibility for civil rights compliance for all agency programs. The Secretary of EOHHS is responsible for Medicaid related discrimination issues and any such complaints will be referred accordingly.

ATTENTION: Language assistance services are available to you free of charge. Call . 1-855-697-4347 (TTY 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-697-4347 (TTY 711)

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-697-4347 (TTY 711)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-697-4347 (TTY 711)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-697-4347 (TTY 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរទូរស័ព្ទ 1-855-697-4347 (TTY 711)

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-697-4347 (ATS 711)

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-697-4347 (TTY 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-697-4347 (TTY 711)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 1-855-697-4347 TTY 711

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-697-4347 (телетайп 711)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-697-4347 (TTY 711)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-697-4347 (TTY 711)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-697-4347 **(TTY 711)** 번으로 전화해 주십시오

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-697-4347 (TTY 711).

Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Ɓàsɔɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá 1-855-697-4347 (TTY 711)

Non-Discrimination Notice

The Executive Office of Health and Human Services (EOHHS) and the Department of Human Services (DHS) does not discriminate on the basis of race, color, national origin, disability, political beliefs, age, religion or gender in acceptance for or provision of services, employment or treatment, in its education and other program activities. Under other provisions of applicable law, EOHHS/DHS does not discriminate on the basis of sexual orientation, gender identity or expression. For further information about these non-discrimination laws, regulations and complaint procedures for resolution of complaints of discrimination, contact DHS at 25 Howard Ave, Bldg. 57, Cranston, RI 02920, telephone number (401) 462-2971 (for deaf/hearing impaired 1-800-745-6575 voice; TTY 711).

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