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

Date : 04/01/2023
Account Number :
Document# :
Notice Type : HXR

MEDICAID RECIPIENT
123 MAIN ST
CITY, RI 12345

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

For questions about affordable health coverage, call HealthSource RI at 1-855-840-4774

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)

RECERTIFICATION /RENEWAL NOTICE

Action Required: Review the Information We Have on File for You

Why Are You Getting This Notice?

It is time for us to review your eligibility for the following programs. If your name is listed in the following box, please complete, sign and return this form along with the requested proof or your benefits may end.

Every year, we must review your case to find out if you still qualify for Medicaid. We decide whether you still qualify based upon the information you provided us. We then check this information using electronic verification tools. We could not determine if you or a member of your household still qualifies for Medicaid based on the information you gave us. In order to continue your Medicaid eligibility and not lose coverage, please carefully read this form and write-in changed information about the beneficiary. Be sure to sign and return the entire renewal form.

Program Name	Name	Date current benefit is scheduled to end
Medicaid		05/31/2023

To make sure you do not have a break in benefits, **return this Renewal Form within 30 days of this notice date** to allow for processing time. Each program may have different procedures for renewal. Please read the information below about how to renew your eligibility for each program.

If you have questions or need help filling out this form, please call 1-855-MY-RI-DHS (1-855-697-4347).

How do I Renew?

MEDICAID:

Account #:

If we have told you that your **Medicaid coverage is scheduled to stop**, this means that we need some information from you to decide whether you are still eligible. The information we need from you is mentioned in the notice below.

- **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.
- **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.

What changes do I need to report?

- **Income:** We need to know about any changes in the income of the beneficiary and any spouse or dependents who are considered when determining the amount that must be paid toward the cost of care each month.
- **Resources:** We also need to know if the resources of the 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 beneficiary has moved or changed addresses, entered or left an assisted living residence, nursing facility or group home, or is in new or different shared living arrangement.
- **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 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.
- **Immigration status:** You must tell us if the immigration status of a non-citizen beneficiary and/or a sponsor has changed since the date of the initial application or last renewal.

How will my Medicaid be renewed?

- 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.

<u>If you need additional space, please use the Customer Comments Section on this renewal form.</u>

If you would like to apply for additional programs, you must complete a new Assistance Application (DHS-2) or apply on-line at healthyrhode.ri.gov. Please contact us at the telephone number listed above to request a new application or visit www.dhs.ri.gov to print one out.

<u>Current Account Information</u>

Account #:

Please check the information below. If the information has changed, please update the information in the "Updated Information" column to the right.

Primary Applicant's Contact Information

Is the contact information below for the primary applicant still correct? ☐ Yes ☐ No - please provide updated information below.

	Current Information	Updated Information
Home Address	123 MAIN ST CITY, RI 12345	
Mailing Address (if different from home address)	123 MAIN ST CITY, RI 12345	
Phone Number	123-456-7890	
Phone Number for DHS to call you for your scheduled interview (if applicable)		
Email		
Preferred Language Spoken	English	
Preferred Language Read	English	

Do you need an interpreter? ☐ Yes ☐ No
If needed, interpreter services are provided free of charge.

Current Household Members

Are the people listed below still living in your home? ☐ Yes ☐ No – if no, please enter the date the person(s) left.

Name	Date of Birth	Relationship to primary applicant	Program(s) renewed	Purchase and prepare meals together?	Date person moved out of the home*
MEDICAID RECIPIENT	DD/MM/YYYY	Self	Medicaid	NA	

*Examples of moving out of the home: new residence, prison, hospital, dormitory, nursing facility, residential program, assisted living, a group home, shared living.

New Household Members

Please complete the chart below to add the names of anyone not listed above, including anyone who moved into your home.

If you need additional space, please use the Customer Comments Section on this renewal form.

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

Account #:

If any of the people that moved into your home are applying for benefits, please check the appropriate boxes in the column to the right.

Name of new household member	Date of Birth	SSN (answer only if applying for benefits)	U.S. Citizen? (answer only if applying for benefits)	Relationship to primary applicant	Benefits Requested
	____/____/____	____ - ___ - ______	[ ] Yes [ ] No		[ ] SNAP [ ] RIW [ ] Medicaid [ ] CCAP [ ] GPA
	____/____/____	____ - ___ - ______	[ ] Yes [ ] No		[ ] SNAP [ ] RIW [ ] Medicaid [ ] CCAP [ ] GPA

Is anyone in your household blind, disabled, pregnant or living in an institution or community residence?

☐ Yes - Please provide information below ☐ No

Name	Has this person been determined blind or disabled by a government agency	Is this person pregnant?	Is person currently living in an institution or community residence? Please specify*
	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes, ____________________ [ ] No
	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes, ____________________ [ ] No

*Living in an institution (Please specify: hospital, nursing facility, residential program, prison);
*Living in a community residence (Please specify: assisted living, a group home, shared living).

Income from Work

Below is the information we have about people in your household who have income from work. **Please attach proof of income for the last 30 days, even if there are no changes** (not required for Medicaid).

Is the information below correct? ☐ Yes ☐ No

If no, please provide the correct information and any new income information in the empty rows provided in the chart below.

Please note that not all of the income you reported may count towards renewal.

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

Account #:

Please include self-employment income such as money received from a business, for caring for children not living in the home, or income from a rental property that is owned or managed by a beneficiary in the household.

Name	Employment Status	Employer's name and address	Total monthly income*

*Total Monthly Income: income before anything is taken out

Income from Other Sources

Below is the information we have about unearned income. **Please attach proof of income for the last 30 days, even if there are no changes** (not required for Medicaid).

This section looks at income from sources other than work such as Social Security, Retirement, Disability Insurance, or Survivor's benefits (RSDI), veterans' benefits including pensions and Aid & Attendance payments, unemployment benefits, income from rental property or leases, Supplemental Security Income (SSI), Temporary Disability Insurance (TDI), Worker's Compensation, interest/dividends on financial accounts, adoption subsidy, military/dependent Allotment, child support, and/or alimony.

Is the information below correct? ☐ Yes ☐ No

If no, please provide the correct information and any new income information in the empty rows provided in the chart below.

Please note that not all of the income you reported may count towards renewal.

Name	Type of income	Amount	How often received

The income displayed in the Income from Work and Income from Other Sources sections of this notice impact your Medicaid benefits that are up for renewal. These are the only income types for which we need updated information. Please report any new sources of income in the space provided.

Child Care Schedule

If you are receiving child care, please fill in the boxes below with your current work schedule and need for services.

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

Account #: ████

Need Reason *(check all that apply)*	[ ] Work [ ] Special Needs due to Child or Parent's Health Condition [ ] High School/GED Completion [ ] Short-term training [ ] College			
	Parent 1 (Name):		**Parent 2 (Name):**	
Day	**Start Time**	**End Time**	**Start Time**	**End Time**
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				
If your schedule varies, please explain how (you may send additional documentation to verify).				

School Attendance and Student Status

Below is the information we have about people in your household attending school. Is the information below correct? ☐ Yes ☐ No

If no, please provide the correct information and any new information in the empty rows provided in the chart below.

Name	Age	School Name	Attending half-time or more? Yes/No	Highest grade completed	Receiving work study? Yes/No	Type of school (K-12, College, Trade School)
MEDICAID RECIPIENT	99	UNKNOWN	No	NA	NA	NA

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

Account #: [redacted]

Access to Other Health Insurance

Name	Policyholder's name?	Name of Plan	Enrollment Status	Claim, contract/ group and/or member ID numbers	Name and address of insurance company

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

Account #: [redacted]

Your consent to share data for eligibility decisions relating to MEDICAID AND HEALTH COVERAGE ONLY
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, your consent is required in order to determine or renew your eligibility using electronic data sources for other programs such as commercial health insurance through HealthSourceRI. 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); 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 initial and continuing eligibility for enrollment in publicly funded health insurance coverage or other publicly funded programs administered through this site that 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 other programs may be affected by this decision.

Account #: [redacted]

PENALTY WARNING

My signature below indicates that I have read or have had read to me the Rights and Responsibilities attached to this form. Under penalty of perjury, I attest that all of my answers on this renewal form are correct and complete to the best of my knowledge, including information about citizenship and immigration status and the identity of the minor children named in this form. I understand that I am breaking the law if I purposely give wrong information and can be punished under federal law, state law or both.

Signature of Applicant or Recipient	Date	Signature of Authorized Representative	Date
Signature of Spouse or Other Parent of Child	Date	Signature of Person Helping you Complete this Form	Date
Signature of Guardian, Conservator or Power of Attorney	Date	Signature of Agency Representative (for office use only)	Date

State of Rhode Island Voter Registration Application

If you are not registered to vote at your current address, would you like to register to vote?
☐ **Yes** ☐ **No**
NOTE: If you do not check either box, you will be considered to have decided not to register to vote at this time.

Applying or declining to register to vote will not affect the amount of help that you will be provided by this department. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application form in private.
If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Voter Registration Coordinator at 50 Branch Avenue, Providence, RI, 02904 or call at (401) 222 - 2345.

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

The chart below shows you some examples of the documents you will need to submit along with this renewal form. Return this completed renewal form even if you don't have all of these documents. If you need assistance obtaining these documents, you may contact DHS at the phone number listed on page 1 of this form.

You can also submit your documents through the HealthyRhode mobile app, available for download on your smartphone.

Job Income	Pay stubs or statement on employer letterhead showing income before taxes, pay dates, hourly work schedule and the number of hours worked for the past four weeks
New Address and Shelter Costs	Rent receipt, mortgage payment book, rent/lease agreement, statement from HUD, statement from person who shares shelter costs, utility bills, statement from utility company, statement from landlord including address and amount paid
Child Support that You Pay	If your obligation to pay child support has changed, provide a copy of the court order.
Unearned Income	Most recent copy of Social Security check or award letter, proof of unemployment, worker's compensation, pension, child support, alimony, TDI
Dependent Care Expenses	Receipt showing your out-of-pocket child care expenses or expenses for caring for a disabled or elderly household member
Resources/Vehicles	Bank account statements (savings, checking, credit union statements and/or CD's); stock shares or bonds; documentation of ownership of a trust; proof of ownership of real property other than your home; proof of rental properties; vehicle registration including car, boat, truck, motorcycle, camper; proof of other income producing property; proof of ownership of a burial plot (if you own more than one)

Account #:

CUSTOMER COMMENTS (may also report additional information here)

RHODE ISLAND
VOTER REGISTRATION FORM

Please print clearly in ink. All information is required unless marked optional.

YOU MAY USE THIS FORM TO:

- Register to vote in Rhode Island.
- Change your name and/or address on your registration.
- Choose a political party or change parties.

TO REGISTER TO VOTE IN RI YOU MUST BE:

- A legal resident of Rhode Island.
- A citizen of the United States.
- At least 16 years of age.
  (You must be at least 18 years of age to vote on Election Day.)

INSTRUCTIONS

Box 2: **REQUIRED.** Rhode Island citizens who are at least 16 years of age may pre-register to vote using this form. If you fail to check either of these boxes, this form will be returned to you. If you checked NO to either of these statements, do not complete this form.

Box 3: If you are registering to vote for the first time in Rhode Island by mail or if someone else turns this form in for you, it is **REQUIRED** that you provide your driver's license number or state ID number issued by the RI Department of Motor Vehicles (DMV). If you do not have either, you must provide the last 4 digits of your Social Security Number. If you do not provide the above information or it cannot be verified, you will be required to provide identification to an election official before voting. Acceptable forms of identification are on the Board of Elections website at http://www.elections.ri.gov or contact your local Board of Canvassers (see reverse side of this form).

Box 5: A person may have only one legal residence. You must register from your legal residence. A post office box or rural route may only be used as a "Mailing Address" in Box 6.

Box 9: If you want to affiliate to vote, choose a party. If you leave Box 9 blank, you will be listed as unaffiliated.

Box 10: You must SIGN and DATE the registration form. If you fail to sign and date the form, it will be returned to you.

Box 11: If you are updating your voter registration because you legally changed your name, enter your previous legal name.

Box 12: If you are updating your voter registration because of an address change, enter your previous address, **even if out-of-state.**

You will receive an acknowledgement receipt of this voter registration form within 3 weeks. If you do not receive it, contact your local Board of Canvassers (see reverse side for list). For questions and deadlines relating to this form, visit the Board of Elections website at http://www.elections.ri.gov or contact your local Board of Canvassers (see reverse side for list).

(This form may be reproduced)

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1. Check Boxes that Apply: ☐ New Voter Registration ☐ Address Change ☐ Party Change ☐ Name Change

2. I am a U.S. Citizen and resident of Rhode Island. ☐ Yes ☐ No

I am at least 16 years of age. (You must be at least 18 years of age to vote.) ☐ Yes ☐ No

If you checked NO to either of these statements, do not complete this form.

3. RI driver's license or ID Number: ______

If you do not have a RI driver's license or ID, enter last 4 digits of your social security number: ______

If you do not enter either number, see instructions for Box 3.

4. Last Name	Suffix (if any)	First Name		Middle Name (or initial)	
5. Home Address (Do not enter a post office box)	Apt.	City/Town		State RI	ZIP Code
6. Mailing Address (If different from Box 5)	Apt.	City/Town		State	ZIP Code

7. Date of Birth (mm/dd/yyyy) — Month Day Year

8. Phone No./ E-mail Address (optional)

9. Party Affiliation: ☐ Democrat ☐ Moderate ☐ Republican ☐ Unaffiliated ☐ Other________________

10. I swear or affirm that:

- I am not incarcerated in a correctional facility upon a felony conviction.
- I am not presently judged "mentally incompetent" to vote by a court of law.
- The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, I may be fined, imprisoned, or (if not a U.S. citizen) deported from or refused entry into the United States.

Official Use For Barcode

PLEASE SIGN FULL NAME OR PLACE MARK BELOW

Date: Signed **(mm/dd/yyyy)**

Are you interested in working at the polls? (check box below) ☐

Warning: **If you sign this form and know it to be false, you can be convicted and fined up to $5,000 or jailed up to 10 years.**

11. PREVIOUS NAME (if different from Box 4)

12. PREVIOUS ADDRESS OF REGISTRATION (City/Town, State, ZIP & County)

02/2012 Regs
Form Revised 12/2012

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

Return Address

Postage Required Post Office will not deliver without proper postage.

Mail To: **BOARD OF CANVASSERS**

*************************FOLD HERE & TAPE AT TOP****************************

INSTRUCTIONS FOR MAILING THE VOTER REGISTRATION FORM

An applicant who chooses to mail his/her voter registration form shall do so in the following manner:

1. Fold the form at the dotted line and tape the bottom to the top of the form.
2. From the list below, locate the address of the board of canvassers in the city or town in which you are registering to vote and insert that address in the appropriate space beneath "**Mail To: BOARD OF CANVASSERS"** on the addressed side of the voter registration form. Insert your return address in the space provided.

NOTICE: *It is against the law for anyone to interfere with your privacy in registering to vote or in choosing a political party. If you believe someone has interfered with your right to register or not register, or with your privacy in making this decision, or in choosing a political party, you may file a complaint with the State Board of Elections, 50 Branch Avenue, Providence, Rhode Island 02904.*

LOCAL BOARDS OF CANVASSERS

Barrington Town Hall, 283 County Rd., Barrington, RI 02806

Bristol Town Hall, 10 Court St., Bristol, RI 02809

Burrillville Town Hall, 105 Harrisville Main St., Harrisville, RI 02830

Central Falls City Hall, 580 Broad St.., Central Falls, RI 02863

Charlestown Town Hall, 4540 S. County Trail, Charlestown, RI 02813

Coventry Town Hall, 1670 Flat River Rd., Coventry, RI 02816

Cranston City Hall, 869 Park Ave., Cranston, RI 02910

Cumberland Town Hall, 45 Broad St., Cumberland, RI 02864

East Greenwich Town Hall, PO Box 111, East Greenwich, RI 02818

East Providence City Hall, 145 Taunton Ave., East Providence, RI 02914

Exeter Town Hall, 675 Ten Rod Rd., Exeter, RI 02822

Foster Town Hall, 181 Howard Hill Rd., Foster, RI 02825

Glocester Town Hall 1145 Putnam Pike PO Drawer B, Glocester, RI 02814

Hopkinton Town Hall, 1 Town House Rd., Hopkinton, RI 02833

Jamestown Town Hall, 93 Narragansett Ave., Jamestown, RI 02835

Johnston Town Hall, 1385 Hartford Ave., Johnston, RI 02919

Lincoln Town Hall, 100 Old River Rd., PO Box 100, Lincoln, RI 02865

Little Compton Town Hall, PO Box 226, Little Compton, RI 02837

Middletown Town Hall, 350 East Main Rd., Middletown, RI 02842

Narragansett Town Hall, 25 Fifth Ave., Narragansett, RI 02882

New Shoreham Town Hall, PO Drawer, 220 Block Island, RI 02807

Newport City Hall, 43 Broadway, Newport, RI 02840

N. Kingstown Town Hall, 80 Boston Neck Rd., North Kingstown, RI 02852

North Providence Town Hall, 2000 Smith St., North Providence, RI 02911

North Smithfield Municipal Annex, 575 Smithfield Rd., North Smithfield, RI 02896

Pawtucket City Hall, 137 Roosevelt Ave., Pawtucket, RI 02860

Portsmouth Town Hall, 2200 East Main Rd., Portsmouth, RI 02871

Providence City Hall, 25 Dorrance St., Providence, RI 02903

Richmond Town Hall, 5 Richmond Townhouse Rd., Wyoming, RI 02898

Scituate Town Hall, PO Box 328, North Scituate, RI 02857

Smithfield Town Hall, 64 Farnum Pike, Smithfield, RI 02917

S. Kingstown Town Hall, 180 High St., Wakefield, RI 02879

Tiverton Town Hall, 343 Highland Rd., Tiverton, RI 02878

Warren Town Hall, 514 Main St., Warren, RI 02885

Warwick City Hall, 3275 Post Rd., Warwick, RI 02886

W. Greenwich Town Hall 280 Victory Highway, W. Greenwich, RI 02817

West Warwick Town Hall, 1170 Main St., West Warwick, RI 02893

Westerly Town Hall, 45 Broad St., Westerly, RI 02891

Woonsocket City Hall, P.O. Box B, 169 Main St., Woonsocket, RI 02895

Voter Registration Questions May Be Addressed To:

Rhode Island Board of Elections
50 Branch Avenue
Providence, RI 02904
elections@elections.ri.gov

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Account #:

Change Reporting Requirements

You must report any of the following changes that may affect the eligibility and enrollment of anyone in your household within 10 days of the date of the change:

- Residential address;
- Mailing address;
- Income;
- Marital status;
- Persons moving in or out of your home, or who is in your tax filing unit;
- Pregnancy status of any person in the household;
- Incarceration or institutional status;
- Access to other health insurance coverage including eligibility for Medicare or access to insurance through your job or through a family member's job;
- Immigration or citizenship status;
- Birth, adoption, placement for adoption, marriage, divorce, or death;
- Federal income tax filing status; or
- The number of tax dependents claimed on federal income taxes.

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.

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

Account #:

YOUR RIGHTS

Information about your Coverage and Rights:

You have a RIGHT to request, and if found eligible, to receive financial or Medicaid or Supplemental Nutrition Assistance Program benefits based on policies and standards established under State and Federal laws and regulations.

You may have the right to appeal and have an Administrative Fair Hearing if you disagree with our decisions. You may:

1. **Call us to discuss the benefit decision.** Contact us at the telephone number at the top of the first page of this notice. Be sure to have this notice and the case/identification number on-hand when you call.
2. **Appeal for an Administrative Fair hearing.** An Appeal is a formal request asking for the decision to be reviewed at an administrative hearing. Please continue reading for further information.

What is a fair hearing?

A fair hearing is a chance for you to tell an administrative hearing officer why you disagree with the agency's decision about your eligibility, benefits, and/or any costs you must pay. An agency representative is also present at the hearing to explain the basis for the agency decision. By law, the administrative officer must review the facts of the case presented by both sides in a fair and objective manner.

Deadlines for appeals and asking for a fair hearing

The chart below explains the deadlines for filing an appeal for each program. For some programs, your benefits or services may be continued until a hearing decision is made if you appeal by the deadlines listed in the chart. If you miss this deadline, you may lose your right to appeal. After you have filed your appeal, we will schedule your hearing and issue a decision within 90 days, or 60 days if the hearing relates to your SNAP benefits. A decision will issue on all HealthSource RI appeals within 90 days of the date an appeal request is received, as administratively feasible.

Account #:

Program	You must file an appeal in:	Will benefits continue if the appeal is made within 10 days of the notice ("Aid Pending")?
Medicaid	30 days after the notice date plus five days for mailing time	Yes, benefits will automatically continue unless you tell us otherwise
SNAP	90 days from the notice mail date	Yes, benefits will automatically continue unless you tell us otherwise
CCAP	30 days from the notice mail date	Benefits may be reduced until a hearing decision is made.
GPA	10 days from the notice mail date	Yes, but the request must be made in writing
Commercial Health Insurance	30 days after the notice date plus five days for mailing time.	You must call HealthSource RI within 30 days of the notice to request Aid-Pending.
All other programs	30 days from the notice mail date	Yes

Expedited Appeals

You have the right to an expedited appeal if you have an immediate need for health services or SNAP benefits and waiting for a standard appeal could seriously jeopardize your life or health, or ability to attain, maintain, or regain maximum function. We must decide expedited appeals as quickly as possible, given the circumstances. If we deny your request for an expedited appeal, we must inform you quickly, and we must handle your appeal through our standard process.

Right to Continue Benefits While Awaiting Hearing

You may have the right to have your benefits continue unchanged while you wait for your hearing (this is called "Aid-Pending"). Except for Commercial Health Insurance through HealthSource RI, if you appeal within 10 days, in most instances, you will be automatically granted Aid-Pending. Unless you can show otherwise, for Medicaid and HealthSource RI, we will assume that you received the notice 5 days after the date on the notice.

If you have Medicaid and you receive Aid-Pending, and then you lose your appeal, the State may make you pay back its costs for covering you during the Aid-Pending period. For HealthSource RI, Aid-Pending is only available if you are appealing an eligibility redetermination that occurred within 30 days of the date you file your appeal, and the request is made by telephone to HealthSource RI at 1-855-840-HSRI (4774). If you are receiving tax credits to help pay for your premiums and you receive Aid-Pending, and then you lose your appeal, then you may owe extra money in your federal taxes next year. If you pay monthly premiums, you must still pay during the Aid-Pending period.

If you receive SNAP, RIW or GPA benefits and receive Aid-Pending, and you lose your appeal, you may need to pay back the benefits you were issued but were not entitled to during this period.

Right to Represent Yourself and Right to be Represented

You have the right to represent yourself at the hearing, or to be represented by anyone you choose, including an attorney, advocate, friend, or relative.

Legal advice is available from Rhode Island Legal Services, Inc. at 274-2652 or 1-800-662-5034. If you choose to have Legal representation, the representative must file a written Entry of Appearance with the Hearing Office at or before the hearing. The Entry of Appearance acts as a release of confidential information, allowing the Legal representative access to the Agency case record. It is also needed for the Hearing Office to confirm the representation for purposes of follow-up, review, request for continuances, etc.

Eligibility of Other Household Members May be Affected

Our appeal decision may result in changes to the eligibility of another member of your household.

Access to Your Case Record

You have the right to see your case record, including any evidence the State will use at your hearing. To view your case record, call us at 1-855-MYRIDHS (1-855-697-4347). If you are appealing an action taken by HealthSource RI, you may request a copy of your record by calling: 1-855-840-HSRI (4774).

Informal Resolution

We may be able to fix your problem quickly without a hearing. Please call 1-855-MYRIDHS (1-855-697-4347) so that we can review your case informally. If you are appealing an action taken by HealthSource RI, you may contact HealthSource RI at 1-855-840-HSRI (4774) to request an informal review of your appeal. We will reach out to you in an effort to resolve your appeal informally. Your right to a hearing will not be impacted by efforts to resolve your issue informally.

If this was your initial application for Medicaid coverage, you must request a hearing in writing within thirty (30) days. To cover mailing time, the 30 days begins the fifth day after the date on this notice. Therefore, you must request your appeal by 05/06/2023.If you are already receiving Medicaid and you want to keep your coverage until a hearing decision is made, you must appeal in writing within ten (10) days. Again, to cover mailing time, the 10 days begins on the fifth day after the date on this notice.

You have a RIGHT to confidentiality. Under state law, all agencies administrating programs are bound by state and federal laws and regulations to use information about you and other members of your household only for purposes directly related to the administration of the programs and in compliance of the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information. HIPAA restrictions prevent us from discussing the health information of you or any member of your household with anyone, including unauthorized representative, unless that individual has power of attorney or you have signed a consent form authorizing the disclosure of this information. This includes disclosure of mental health information, HIV, AIDS, STD test results or treatment and chemical dependency services.

The EOHHS and DHS do not release information about you or other members of your household without your consent except as provided in Rhode Island General Laws , , and , regulations set forth in the DHS Administrative Code and Medicaid Codes of Administrative Rules. Any person found guilty of violating the provisions of Rhode Island General Laws shall be deemed guilty of a misdemeanor. Violators are subject to a maximum fine of two hundred dollars ($200), or imprisonment of up to six (6) months, or both.

You have a RIGHT to apply for support enforcement services through the Office of Child Support Services. To get an application for these services, go to **http://www.cse.ri.gov/** or visit your local Office of Child Support Services at 77 Dorrance St., Providence, RI 02903.

You have a RIGHT to name an authorized representative. An authorized representative is a person designated by the head of the household or the spouse, or any other responsible member of the household, to act on behalf of the household in applying for program benefits, or using the benefits. The authorized representative for benefits may or may not be the same individual designated as an

authorized representative for the application process or for meeting reporting requirements. The authorized representative designation must be made in writing.

If you are applying for Medicaid affordable health care coverage, the EOHHS requires that the Department must:

- Provide you with thirty (30) days to give us the information we need to review your eligibility. If you don't give us the information or ask for more time we may deny, close, or change your health care coverage.
- Notify you, in most cases, at least ten (10) days before we stop your health care coverage.
- Give you a written decision, in most cases, within thirty (30) days. Health care coverage and some disability cases may take forty-five (45) to ninety (90) days.
- Continue Rhode Island Medicaid coverage while we decide if you are eligible under another program.

YOUR RESPONSIBILITIES

Information about your Coverage and Responsibilities:

You have a RESPONSIBILITY to supply accurate information about your income, resources and living arrangements on this application.

You have a RESPONSIBILITY to provide Social Security numbers (or proof that you have applied for one) for yourself and the members of your household, as a condition of eligibility. The collection of information on the application, as well as the Social Security numbers of all members of your household for whom you receive assistance, is authorized under the Food and Nutrition Act of 2008 (formerly the Food Stamp Act), as amended, 7 U.S.C. 2011-2036 and under Federal Law (and). This information will be used to determine whether your household is eligible or continues to be eligible to participate in SNAP, Medicaid, RIW, GPA, CCAP, and/or Commercial Health Insurance with Financial Help. The Department will verify this information through computer matching with the Department of Labor and Training, the Social Security Administration, the Internal Revenue Service, the Food and Nutrition Service, and other governmental and non-governmental entities authorized by law, regulation or contract, and they will be subject to verification by Federal, State, and local officials. The income and eligibility information obtained from these agencies will be used to make sure your household is eligible for and receiving the correct amount of SNAP benefits, GPA, Child Care, RIW, Medicaid, and Commercial Health Insurance with Financial Help. This information will also be used to monitor compliance with program regulations, for program management as well as to prevent fraud and verify health care claims.
This information may be disclosed to other federal and state agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a claim arises against your household, the information you provided on your application, including all SSNs, may be referred to Federal and State agencies as well as private claims collection agencies for claims collection action. Providing the requested information is voluntary. However, failure to provide a SSN will result in the denial of benefits to any individual applying for benefits. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.
You have a RESPONSIBILITY to cooperate fully with state and federal personnel conducting quality control reviews.

You have a RESPONSIBILITY to cooperate with the Office of Child Support Services if you receive RI Works, Child Care Assistance or Medicaid. You must help establish, modify, or enforce child support for

the child(ren) in your care, and establish paternity (if necessary). If you can show that you have a good reason to believe that cooperating with the Office of Child Support Services puts you, your children, or the children in your care at risk of harm from the non-custodial parent, you may claim good cause not to cooperate.

RI WORKS PROGRAM, MEDICAID, CHILD CARE ASSISTANCE AND GENERAL PUBLIC ASSISTANCE

LIENS AND ASSIGNMENTS

Pursuant to Rhode Island General Law, Sections 40-6-9, 40-6-10, or 40-8-15, without the necessity of signing any document:

a.) Regarding Child Support and Establishment of Paternity

I have assigned any and all rights that I may have for and on behalf of myself, and for and on behalf of my child or children, to the Department of Human Services (DHS) whether acting on its own or as an eligibility agent of the Executive Office of Health and Human Services (EOHHS), against any person failing to provide for support, maintenance, and medical care for myself and my minor child or children for whom assistance is paid by either or both agencies. In this capacity, the DHS is authorized to institute a suit to establish paternity and/or to collect support for myself or my child or children who receive or received assistance from the DHS and/or EOHHS. If I stop getting financial assistance or Medicaid, I must tell the Office of Child Support Services about any changes that affect child/medical support such as if my child moves out of my home or there is a change in my address.

b.) Regarding Amounts Recoverable from a Third Party

I have assigned any and all rights to the DHS or EOHHS, for and on behalf of myself and any person who I am legally authorized to represent, for amounts recoverable from a third party equal to the amount of financial assistance and Medicaid provided as a result of accident, injury, or illness.

c.) Regarding Amounts Recoverable from Workers' Compensation

The Department of Human Services and/or Executive Office of Health and Human Services may place a lien upon any pending award, order, or settlement, which I may be entitled to under the provisions of the Rhode Island Workers Compensation Act, Chapters 28-29 through 28-38 of the Rhode Island General Laws. The purpose of the lien is to secure reimbursement to the State for financial and Medicaid payments made to me or on my behalf for the period of time for which workers' compensation award, order, or settlement is made.

d.) Regarding Lien on Deceased Recipient's Estate for Medicaid Reimbursement

In accordance with R.I.G.L. 40-8-15, the EOHHS may place a lien upon the estate of a Medicaid recipient who was fifty-five (55) years of age or older at the time of death. For purposes of this section the term "estate" with respect to a deceased individual shall include all real and personal property and other assets included or includable within the individual's probate estate. The total sum of Medicaid paid on behalf of a Medicaid recipient who was fifty-five (55) years of age or older at the time of receipt is a debt to the state and constitutes a lien upon the estate of the recipient in favor of the EOHHS. However, the lien is effective and does not apply to the estate of a recipient who is survived by a spouse, or a child who is under the age of twenty-one (21) or a child who is blind or permanently and totally disabled as defined in Title XVI (SSI) of the Social Security Act. Tribal lands and certain properties belonging to American Indians and Alaskan Natives may be exempt from recovery.

Account #:

I understand that my application serves as authorization to the EOHHS and/or DHS to obtain from Medical providers information that is pertinent to me or to any person included in my application for as long as the case remains open. I understand and agree that the EOHHS or its eligibility agent, DHS, may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.

I also understand that EOHHS and DHS can use or share information I provided on my application and in my private account for the administration of any programs for which I applied and/or may be providing me with benefits in accordance with state and federal law, contract and regulation. The EOHHS and DHS can release non-identifying information for research purposes. Any release of identifying information must be done in accordance with state and federal law.

Medicaid: Termination by You

The following member(s) of your household have Medicaid coverage:

Name
MEDICAID RECIPIENT

You may terminate the Medicaid health coverage of any member of your household at any time. We offer several ways to process your request for termination:

- By Phone: call the Department of Human Services' (DHS's) Call Center at 1-855-697-4347 (Monday through Friday, except holidays, from 8:30am-3pm) or HealthSourse RI at 1-855-840-4774 (Monday through Friday, except holidays, from 8am-6pm)
- In Person: visit a DHS office or put your request for termination in any of the secure drop boxes at DHS offices and Regional Family Centers. For office locations, visit **www.dhs.ri.gov** or call 1-855-MY-RI-DHS (1-855-697-4347)
- By Mail: You can also make the request in writing at least two weeks before you want coverage to end and mail it to: State of Rhode Island, P.O. Box 8709, Cranston, RI 02920-8787

♥Medicaid: Termination by State

The following member(s) of your household have Medicaid coverage:

Name
MEDICAID RECIPIENT

Your coverage, or the coverage for any member of your household in Medicaid can be cancelled only if the following things happen:

- if you or your household member are no longer eligible for affordable coverage
- if you or your household member's coverage is ended due to fraudulent information in your application.

If you have special health care needs

You and members of your household might qualify for more services through Medicaid if anyone in your household has special health care needs.

- Does anyone in your household have a disability?
- Does anyone in your household need nursing home care or other long term care services?
- Does anyone in your household have high or frequent medical bills?

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

If so, find out if they qualify based on special health care needs. Call (855) 712-9158 or visit www.HealthSourceRI.com for more information.

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។ ចូរ ទូរស័ព្ទ 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, ໂດຍບໍ່ເສັຽຄ່າ, 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 [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɖá 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).

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