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

Date : 04/01/2023
Case Number : 775219683
Document# : 22442995

MEDICAID RECIPIENT
123 MAIN ST
CITY, RI 12345

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)

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

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 external verifications and the information you gave us. In order to continue your Medicaid eligibility and not lose coverage, please review this entire notice, update information where applicable, sign and return the renewal form by the date listed below. If you do not provide a signed renewal form by the date listed below, the system will evaluate and determine your eligibility for health insurance coverage options accordingly.

Program Name	Name	Date current benefit is scheduled to end
Medicaid	[redacted]	06/01/2023

Please submit the following document(s) and a signed renewal form by the date(s) listed below. If you do not provide document(s) by the date(s) listed below, the system will evaluate and determine your eligibility for health insurance coverage options accordingly.

Name	We need information about:	Information due by:	Examples of acceptable proof(s) (Please return one of the following):

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

G[redacted] P[redacted]	Unearned Income (including Temporary Disability Insurance, or, Retirement, Survivors, Disability Insurance)	05/01/2023	Recent check stub(s) Letter or document from person/agency making payment Court records or other legal document Attorney records Letter from tribe Statement from lender Bank or other financial statement Award letter AP-91 Loan contract Court Order for Child Support Statement from parent providing care Support agreement

This form must be returned by 05/01/2023. If we do not receive this signed formed by that date, your Medicaid LTSS eligibility coverage will not be renewed and you will lose coverage on 05/31/2023.

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 **GP**[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.

LTSS Renewal Form

Directions: Please carefully read this form and write-in changed information about the beneficiary. Be sure **to sign and return the entire renewal form**, including this page, even if you have no changes to report.

Beneficiary's Contact Information

	Current Information	Updated Information
Primary Contact and Relationship to Beneficiary	[redacted]t Self	
Mailing Address	[redacted] 35758	
	Current Information	Updated Information
Address where LTSS Beneficiary Lives now	[redacted] 02861	
	Current Information	Updated Information
Phone Number	808[redacted]	
Email	[redacted]@gmail.com	
Name of Authorized Representative	Current Information	Updated Information

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

Name	SSN	DOB	Relationship to LTSS Beneficiary	Income/ Type
G[redacted] P[redacted]	XXX-XX-[redacted]	[redacted]939	Self	$ 2,524.90/ RSDI (Retirement, Survivors, and Disability Insurance)

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	-	
[redacted]	Other	$ 100,000.00	

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)

_____
_____
_____
_____.

<table>
<tr><td colspan="3">PENALTY WARNING</td></tr>
<tr><td colspan="3">“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.”</td></tr>
<tr><td>Signature of Client or Authorized Representative
Date:</td><td colspan="2" rowspan="3"></td></tr>
<tr><td>Signature of Spouse or parent
Date:</td></tr>
<tr><td>Signature of Guardian/Conservator/Holder of power of attorney
Date:</td></tr>
<tr><td>Signature of Department Witness
Date:</td><td colspan="2"></td></tr>
<tr><td>Telephone Number</td><td>( )</td><td></td></tr>
</table>

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.

Instructions to the Examining Provider

Your patient is applying for services from the Department of Human Service (DHS). You are requested to complete this form so that the Office of Medical Review (OMR) can determine the **Level of Care**.

Documentation is required to assist in rendering services that best meet this client's **current** needs, either in a Nursing Facility or with Community Services.

What is needed from you to ensure completion of this application:

1. Please complete this PM-1 thoroughly, returning it to the designated Long Term Care Office in a timely manner. **All sections must be completed**.
2. The PM-1 is essential; other medical information is encouraged, i.e. medication sheets, but not in substitution of this form.

As the examining provider (MD, DO, RNP, PA) you will be assessing your patient's **medical diagnosis, current functional activity, cognitive status and treatments**. (Please use the included codes in the Current Functional Activity Section.)

Thank you in advance of your assistance.

Activities of Daily Living
(See Current Functional Activities)

TRANSFER: ability to move between surfaces. To or from, bed, chair, wheelchair, standing position excluding to/from bath or toilet (with or without assisted device)

AMBULATION: ability to move between locations in the individual's living environment (with or without assisted device)

BED MOBILITY: ability to reposition body, turning side to side

DRESSING: ability to put on, fasten and take off all items of clothing

BATHING: ability to take a bath, shower, or sponge bath (effectively and thoroughly) and ability to transfer in/out of tub or shower (with or without assistance device)

TOILETING: ability to transfer on/off toilet, cleanses self after elimination, change pad/brief, manage ostomy or catheter, and adjust clothes

EATING: ability to eat and drink using routine or adaptive utensils (this also includes the ability to cut, chew and swallow food)

PERSONAL HYGIENE: ability to comb hair, brush teeth, wash and dry face, hands and perineum

MEDICATION MANAGEMENT: ability to identify and take medications correctly at the right time, route and dose

Provider Medical Statement

Date:	Date of Last Office Visit:
Applicant Name:	Date of Birth:
SSN# or MID:	Gender (Circle): Male / Female
Address:	Apt/Floor:
City/Town:	State: ZipCode:
Current Living Arrangement (Circle): Lives Alone / Lives with Others / Other:	
Name of Facility:	Date Admitted:

DIAGNOSIS: Medical & Behavioral (including severity of condition) *NO DIAGNOSIS CODES		
PRIMARY DIAGNOSIS (Dates)	**OTHER DIAGNOSIS (Dates)**	**SURGERY/INFECTIONS (include dates)**

Prognosis of Rehabilitation Potential: _____
Permanent Disability (circle): Yes / No

MEDICATIONS: Name, Dose, Frequency, and Route		

PAIN ASSESSMENT

0 1 2 3 4 5 6 7 8 9 10 Diagnosis: _____ Frequency: _____
(none) (moderate) (Severe)

Does pain interfere with individual's activity or movement? (circle) Yes / No

Is pain relieved by medications/treatment? (circle) Yes / No

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

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PRESENT TREATMENTS & FREQUENCY
Provider Orders (Include specific orders for Diet, PT/OT/ST, Oxygen)

Therapies:	**Wound Care: Site(s) _____**
PT ____ x's/wk for ____ /wk's	**(treatment) _____**
OT ____ x's/wk for ____ /wk's	**Pressure Ulcers #**
ST ____ x's/wk for ____ /wk's	**Stage ____ Size ____ cm**
Respiratory Therapy _____	**Bladder & Bowel Training ☐**
Oxygen Liters ____PRN ☐ Cont ☐	**Incontinence:**
Chemotherapy/Radiation ☐	**Bladder ☐ Yes ☐ No Frequency ___**
Dialysis ☐	**Bowel ☐ Yes ☐ No Frequency ____**
Diet _____	**Foley ☐ Colostomy ☐ Urostomy ☐**
Tube Feeding_____	

Current Functional Activity Codes (USE THESE CODES)

0 = INDEPENDENT: NO TALK, NO TOUCH
No help or oversight provided to the individual during the activity (with or without the use of an assistive device)
1 = SUPERVISION: TALK, NO TOUCH
Oversight, cueing, and encouragement provided to the individual during the activity (with or without the use of an assistive device)
2 = LIMITED ASSISTANCE: TALK AND TOUCH
Individual highly involved in activity, received physical **guided assistance, no lifting** of any part of the individual
3 = EXTENSIVE ASSISTANCE: TALK, TOUCH AND LIFT
Individual performed part of activity **but** caregiver provides physical assistance to **lift, move or shift individual**
4 = TOTAL DEPENDENCE: ALL ACTION BY CAREGIVER
Individual does not participate in any part of the activity
5 = ACTIVITY DID NOT OCCUR: NO ACTION
The activity was not performed by the individual or caregiver

Activities of Daily Living (ADL's)	**Please circle all that apply:**	**Instrumental (ADL's)**
_____Bed Mobility	**Cane, Walker, Wheelchair, Bed to Chair,**	**_____Housekeeping**
_____Dressing	**Bedridden, Fall Risk**	**_____Meal Prep**
_____Bathing		**_____Shopping**
_____Toileting		**_____Laundry**
_____Eating		
_____Personal Hygiene		
_____Medication Management		
_____Ambulation		
_____Transfer		

Can the patient go out unaccompanied? Yes / No
Can the patient utilize public transportation independently? Yes / No

COGNITIVE STATUS

Is the patient impaired? (Circle) Yes / No

MMSE Score_____ BIMS Score_____ Date_____

Cognitive Skills for Daily Decision Making (please check one)

☐ **Independent: Decisions consistent/reasonable**

☐ **Modified Independence: Some difficulty in new situations only**

☐ **Moderately Impaired: Decision poor/cue/supervision required**

☐ **Severely Impaired: Never/Rarely makes decisions**

Behaviors: Please circle all that apply.
Please include level of severity on the line provided: 1 = Mild 2 = Moderate 3 = Severe

___Disoriented	___Agitated	___Wander
___Memory Loss	___Verbally Aggressive	___Elopement
___Resists Care	___Physically Aggressive	___Other

Is patient followed by psych services: Yes / No If Yes, Where?
_____

Has patient been hospitalized for Psychiatric Diagnosis? Yes / No (If Yes, give details)

Date:_____ Hospital:_____

Diagnosis: _____

If nursing home placement is medically necessary, will the patient be likely to return to the community within 6 months? Yes / No

Provider's (MD, DO, RNP, PA) Name (Print) _____
Signature: _____ Date: _____

For Office Use Only

Social CaseWorker:_____ District Office: _____

Date Form sent to Provider:_____ Date Received: _____

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STATE OF RHODE ISLAND
P.O. BOX 8709
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AUTHORIZATION TO OBTAIN OR RELEASE CONFIDENTIAL INFORMATION

This form is not intended to be used as a Medical Release form.
Please do not include any Medical information on this form.

I hereby authorize the Rhode Island Department of Human Services to obtain from, or release to:

Name_____
Person, Agency, or Organization

Address_____

the following information pertinent either to me or to the person listed below for whom I am responsible:

Financial Information_____
(Specify) (Dates)

Social Information_____
(Specify) (Dates)

Other Information_____
(Specify) (Dates)

Name (printed)_____
Person about whom information is requested

Date of Birth_____**Social Security Number**_____

VA Claim Number_____

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

Address_____

Reason for Request_____

I understand that records are protected under the General Laws of Rhode Island and cannot be disclosed without written consent, except as otherwise specifically provided by the law. Any information released or received as a result of this consent shall not be further relayed in any way to any person, or organization outside of the department, without an additional written consent from me, unless it is for the purpose of processing my application for assistance or services. This consent is voided at the termination of assistance or withdrawal from services or can be terminated at any time.

_____

Signature of Client, Parent, or Guardian Relationship to above Date

_____

Name (printed)_____

DHS Agency Representative Title

District Office Address_____

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.

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AUTHORIZATION FOR DISCLOSURE/USE OF HEALTH INFORMATION

DIRECTIONS: COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____, hereby voluntarily authorize the disclosure of information from my record.

(Name of Applicant/Patient)

My Date of Birth: ___ / / My Social Security Number: - -

II. My information is to be disclosed by: **And is to be provided to**:

_____ _____

(Name of Person/Organization) *(Name of Person/Organization)*

_____ _____

(Address) *(Address)*

_____ _____

(City, State, ZIP) *(City, State, ZIP)*

III. The purpose or need for this release of information is:

☐ I am applying for Medical Assistance ☐ My own personal and private reasons

☐ I am applying for other DHS Services ☐ Other(*specify*)_____

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

IV. The information to be disclosed: (*check only ONE of the following boxes*)

- ☐ Entire Health Record
- ☐ Health Insurance Information
- ☐ All of the information (Except the boxes I checked) in section VI below
- ☐ Other (s*pecify):* _____
- ☐ **Psychotherapy notes ONLY (by checking this box, I waive my psychotherapist-patient privilege)**

I would also like the following sensitive information disclosed (check the applicable box(es))

- ☐ Alcohol/Drug Abuse Treatment/Referral
- ☐ HIV/AIDS-related Treatment
- ☐ Sexually Transmitted Diseases
- ☐ Mental Health (Other than Psychotherapy notes)

V. I understand that if I am applying for enrollment, recertification, or other services, this release covers all my medical/health care providers, including the provider named above as well as any other person, facility, program or plan I have told you about on my written application(s) for Department of Human Service programs, and on the necessary DHS forms, specifically the AP-70 forms and the MA-63 forms. I understand further that this authorization is required as a condition of obtaining eligibility and services and shall be used DHS only for such purposes. Therefore, failure on my part to sign this authorization may affect my eligibility and/or the scope of services I may obtain.
Additionally, I agree to the use of a fax or a photocopy of this form for the release or disclosure of the information.
I also understand that I may revoke this authorization in writing at any time to the DEPARTMENT OF HUMAN SERVICES and that, if I do, DHS may condition my eligibility and access to services on my decision to revoke. In addition, any information disclosed to DHS before I revoked this authorization, as well as any information disclosed to other parties by this authorization, may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR part 164], and the privacy Act of 1974[5 USC 552a]. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event on the line below.

(Enter if different from one year after the date below) _____

_____ _____

Signature of the Patient **Date**

_____ _____ _____

Signature of Authorized Representative **Relationship to Patient** **Date**

VI. Specific Information I do NOT want disclosed: *(check the applicable box(es))*

☐ Discharge Summary w/lab data	☐ Progress notes	☐ Laboratory Data	☐ Psychiatric Exam
☐ History & Physical Examination	☐ Treatment Plan	☐ Psychological Test	☐ Social Service History
☐ Vocational	☐ Medical	☐ Educational	☐ Financial
☐ Minimum Data Set	☐ Nurses' Notes	☐ Care Plans	☐ Dental Records
☐ Photos/ Videos/ Digital Images	☐ Billing Statements	☐ Consultant Reports	☐ Dietary Records
☐ Emergency Care Records	☐ X-ray reports	☐ Diagnostic Results	

Instructions for Completing Form DHS-25M
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

1. Print legibly in all fields using black ink.
2. Section I - print name of the patient whose information is to be released.
3. Section II - print the name and address of the person/organization authorized to release the information. Also, provide the name of the person, unit and address that will receive the information.
4. Section III - state the reason why the information is needed (e.g., disability claim, continuing medical care)
5. Section IV - check ONE of the listed boxes
    a) Entire Record- the patient's complete medical record except for the sensitive information (e.g., alcohol/drug abuse treatment referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health/ other than psychotherapy notes)
    b) All of this information(except the boxes I checked) in section VI below - the patient should check only those boxes the patient does NOT wish to have disclosed
    c) Other (specify)- specific information specified by the patient (e.g. CHS, billing, employee health)
    d) Psychotherapy Notes ONLY- in order to authorize the use or disclosure of psychotherapy notes, only this box should be checked on this form. Authorizations for the use or disclosure of other health record information may NOT be made in conjunction with authorizations pertaining to psychotherapy notes.
    Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

e) RELEASE OF SENSITIVE INFORMATION - check alcohol-drug abuse treatment/ referral, HIV/AIDS-related treatment, sexually transmitted diseases, mental health (Other than psychotherapy notes) - patient must check the appropriate box!

6. Section V - sign and date. If a different expiration date is desired, specify a new date.
7. Section V - Authorized representative (e.g., legal guardian, power of attorney)
8. Section VI - Specific information the patient does NOT want disclosed.
9. A copy of the completed Form DHS-25M will be given to the patient.

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 [B̀àsɔ́ɔ̀-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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