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

Date : 04/01/2023
Case Number : 501006277
Document# : 22436729

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

MEDICARE PREMIUM PAYMENT PROGRAM (MPPP) RENEWAL

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 Medicare Premium Payment Program (MPP). 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 MPP coverage based on external verifications and the information you gave us. In order to continue your MPP 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 MPP coverage options accordingly.

Program Name	Name	Date current benefit is scheduled to end
Medicare Premium Payments	MEDICAID RECIPIENT	06/01/2023

Please submit the following document(s) and a signed renewal form by the date(s) listed below. In order to avoid losing your MPP benefits, please provide the requested documents, along with a signed and completed renewal form

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

MEDICAID RECIPIENT	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 MPP eligibility will not be renewed and you will lose coverage on 05/31/2023 .

What changes do I need to report?

- **Income**: Any changes in the income of the MPP beneficiary and any spouse or dependents who are considered when determining eligibility.
- **Resources**: Any changes in the resources of the MPP beneficiary and spouse/dependents included in the beneficiary's household.
- **Address and living arrangement:** If the MPP beneficiary and spouse/dependents have moved or changed addresses, entered or left an assisted living residence, nursing facility or group home or shared living arrangement.
- **Family and household circumstances**: If the spouse or a dependent of the MPP beneficiary has died, received a divorce, married someone else, or moved into or out of a house that is NOT counted as a resource.

How can I report changes?

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.
- **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.

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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 If you d[redacted]member 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.

MPP 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] Self	
Mailing Address	[redacted] 1, Pawtucket, RI 02860	
	Current Information	Updated Information
Address where MPPP Beneficiary Lives now	[redacted] et, RI 02860	
	Current Information	Updated Information
Phone Number	774[redacted]	
Email	[redacted]@gmail.com	
	Current Information	Updated Information
Name of Authorized Representative		

1. Income:

Since the beneficiary initially applied or was last renewed, have there been any changes in income? We need to know about any changes in the income of the beneficiary and the names and income of any spouse/dependents we must consider when determining eligibility.

If the boxes are blank, please provide this 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.

☐ Check if NO changes in income to report.

Name	SSN	DOB	Relationship to Beneficiary	Income /Type
C			Self	$ 977.00 / RSDI (Retirement, Survivors, and Disability Insurance)

2. Resources

Since the MPP beneficiary initially applied or was last renewed, have there been any changes in the resources the beneficiary and his or her spouse owns, including any increases or decreases? If the MPP beneficiary's resources have changed list them below in 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
	Checking/Savings	-	
	Stocks/bonds	-	
	Certificates of Deposit	-	
	Money Market Accounts	-	
	Ownership of a Business	-	
	Annuities	-	
	IRA, 401K, 403B,Keogh Accounts	-	
	Other	-	

2a. Trusts.

If the MPP 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. 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.

☐ Check if NO changes in health insurance coverage to report

Health Insurance	Policy Holder's Name	Policy Number	Monthly Premium

<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.”

I understand I can view the DHS Publication 1010, Important Things About Programs & Services, at www.dhs.ri.gov.
My signature below indicates that I have read or have had read to me the Rights and Responsibilities attached to this application. Under penalty of perjury, I attest that all of my answers on this application 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 application. 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.</td></tr>
<tr><td>Signature of Client or Authorized Representative
Date:</td><td colspan="2" rowspan="3">Signature of Department Witness
Date:</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>Telephone Number</td><td>( )</td><td></td></tr>
</table>

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

YOUR CONSENT TO SHARE DATA FOR ELIGIBILITY DECISIONS
We can help you better if we are able to work with other agencies and professionals that know you and your family. By checking the "I Agree" box, you are giving permission for us to obtain, use and share confidential information about you from a variety of sources including the R.I. Department of Labor and Training, the R.I. Department of Human Services, the R.I. Executive Office of Health and Human Services, the R.I. Department of Health, the R.I. Department of Corrections, and Experian on behalf of Centers for Medicaid and Medicare Services (CMS) and the Social Security Administration. We will not refuse you any benefits or access to any programs for which you are eligible simply because you do not give us permission to obtain, use and share confidential information. However, without your consent, we are unable to assist you in accessing certain programs and supports for which you may be eligible. Your consent is required in order to determine your eligibility. You can proceed to shop for and purchase health insurance coverage without completing this consent by contacting our Contact Center at 1-855-840-HSRI (4774), but if you would like to know whether you are eligible for any financial help for the purchase of coverage, whether you are eligible for Medicaid, it will be necessary for you to complete this consent. All information sharing and use that you are authorizing by checking the "I Agree" box will be done in compliance with all relevant federal and state laws and regulations protecting your privacy, including but not limited to: The Health Insurance Portability and Accounting Act of 1996 (Pub. L. 104-191 known as HIPAA); The R.I. Confidentiality of Health Care Communications and Information (R.I.G.L. 5-37.3-1 et seq.); R.I.G.L. 28-32-5, 28-36-12, 28-42-38, 28-39-19, 28-39-22, 40.1-5-26, 23-3-23, 42-12-22, 40-6-12 and all other applicable laws and regulations. Information will be shared by computer data transfer. By checking on the first box below, I consent to the obtaining and use of confidential information about me to determine my eligibility for enrollment in publicly funded health insurance coverage or other publicly funded programs administered through this site, plan, provide, and coordinate benefits and payments. ☐ I give my consent to share data for eligibility decisions ☐ I do *not* give my consent and understand that my eligibility for certain programs and supports will be affected by this decision

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

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

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

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

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

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

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

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

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ 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, 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 dyédé 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).

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