

Additional Comments:

Return this completed form by mail or fax to:

Executive Office of Health & Human Services
Virks Building 3 West Road, Suite 227
Cranston, RI 02920
<http://www.eohhs.ri.gov/>

Tel: 401-462-3295
Fax: 401-462-3297

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Rev.

3/20/20 GP

Financial Information

Your household gross annual income*(what is reported on your tax return)

\$ _____

Dependents (what is reported on your tax return)

_____ (#)

Housing Status

- Permanent (rent or own)
 Temporary (shelter, family/friends, facility)
 Homeless

Total Liquid Assets**(see definition and exclusions below) \$

Employment

Are you currently employed? Yes No

***Gross household income means total income before taxes and deductions. Your household income includes all earnings and support, including SSDI, SSI, unemployment compensation, and other benefits, as well as, income from a legal spouse. Remember to attach proof of income, a copy of your most recent tax return for the most recent tax year, along with 2 most recent check stubs. If self-employed, include a copy of your most recent federal tax return or Mocked MAGI worksheet. If you have no earnings, please include a letter from your case manager stating that you have no income and describing how you are being supported. In addition to this letter, you will also need to complete a Mocked MAGI Worksheet.**

****Liquid assets include any savings, checking, or money market accounts, stocks/bonds, investments, or other easily convertible assets EXCEPT for your primary residence and automobile.**

Insurance/Health Care Coverage

Please indicate if you have or qualify for any of the following programs. If yes, provide your ID or Card # and/or name of insurer/carrier. If no, indicate if you have applied and when (if applicable).

Medicaid/Medical Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No ID/Card# _____ <input type="checkbox"/> Managed Care? <input type="checkbox"/> HMO?	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No Date applied: _____
Medicare	<input type="checkbox"/> Yes <input type="checkbox"/> No ID/Card# _____	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No Date applied: _____
Medicare Part D (Pharmacy Benefit)	<input type="checkbox"/> Yes <input type="checkbox"/> No ID/Card# _____ Plan Name: _____	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No Date applied: _____
Rite Care	<input type="checkbox"/> Yes <input type="checkbox"/> No ID/Card# _____	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No Date applied: _____
GPA	<input type="checkbox"/> Yes <input type="checkbox"/> No ID/Card# _____	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No Date applied: _____
EOHHS Rhode Island Federally Assisted Program (RIFAB)	<input type="checkbox"/> Yes <input type="checkbox"/> No ID/Card# _____ Name: _____	Does your prescription benefits require you to use a mail order pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No Insurers Date Ended _____

Private Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No ID/Card# _____ Name: _____	Does your prescription benefits require you to use a mail order pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No Insurers Date Ended _____
Veterans Administration (VA)	<input type="checkbox"/> Yes <input type="checkbox"/> No ID/Card# _____	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No Date applied: _____ Date Ended _____
Other Public Assistance (specify) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No ID/Card# _____	If no, have you applied? <input type="checkbox"/> Yes <input type="checkbox"/> No Date applied: _____ Date Ended _____
Is APRI helping you with COBRA/Health Insurance payments? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<p>*Remember to attach a copy of your insurance card for any of the programs above in which you participate. Insurance information and a copy of your card are REQUIRED for enrollment.</p>		
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Pharmacy*		
Store Name	Phone () _____-_____	Do not write in this space
Address		<input type="checkbox"/> Pharmacy contacted Date: _____
<p>*Pharmacy information is REQUIRED.</p>		
Would you be interested in participating in a Survey for EOHHS? <input type="checkbox"/> Yes <input type="checkbox"/> No Focus Group for EOHHS? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which is the best way to contact you? (by phone please list phone number, by email please list email address) Phone _____ email _____		
Client Certification and Signature		

I fully understand that by applying for this program, I am divulging personal information that will be used to assist The Executive Office of Health & Human Services in providing me with benefits associated with The RI Drug Assistance Program. I understand this information will be kept confidential, (§23-6-17 Confidentiality, §23-6-18 Protection of Records) but will be used by staff to review my eligibility for this program. Also, by signing this form, I understand that the information contained within may be used to verify HIV status, receive information from my physician about my care, or obtain other necessary information to provide me with these benefits. By applying for this program, I fully understand that this does not mean that my application will be accepted, as funds are limited, and eligibility requirements must be met. In addition, I understand The Executive Office of Health & Human Services reserves the right to terminate benefits due to non-adherence to medication pick up, not recertifying every 6 months, a lack of funds and/or fraudulent claims on behalf of an applicant. **I also understand that this program is a payer of last resort, meaning that I must exhaust all other possible sources of payment for these services before applying for this program.** Lastly, I understand that it is my responsibility to provide The Executive Office of Health & Human Services with truthful information and documentation about my financial, employment, insurance, and HIV status.

I certify that the information provided in this application is true and correct as of the date below and acknowledge that any intentional or negligent misrepresentation of the information may result in nullification of this application and liability for money granted.

1. **It is my responsibility to re-apply (recertify) every 6 months on or before my birth month and 6 months following. If I do not recertify, my Drug Assistance benefits will be terminated.**
2. **It is my responsibility to pick up medications prescribed to me. I understand if I do not adhere to medication(s) prescribed, my Drug Assistance benefits will be terminated.**

Lastly, I certify that I have received and agree to all the terms in **The EOHHS RI Drug Assistance Program Client Agreement Statement.**

Signature _____ Date _____

Print Name _____

Checklist

Please submit all required forms and documents at one time via fax or mail to the address at the bottom of the page. Incomplete applications will delay your enrollment and access to this program.

Did you remember to:

- Attach proof of Rhode Island residency** (copy of lease, utility bill with address, driver's license, etc.)?
- Attach proof of income** (e.g., copy most recent tax return along with 2 most recent pay stubs or Mocked MAGI worksheet)?
- Include a completed Medical Enrollment Form** (next page) **signed by your provider/physician?**
- Attach copy (-ies) of any health insurance or benefits cards?**
- Include your case manager's signature on page 1?**
- Sign the client agreement above?**

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Rhode Island EOHHS Drug Assistance Program MEDICAL Enrollment Form

Client Code

Do not write in this box →

Rhode Island EOHHS Drug Assistance Program Client Agreement Statement

The following are guidelines that must be followed for you to receive drug coverage through the Rhode Island EOHHS Drug Assistance Program. The RI EOHHS Drug Assistance Program will keep your information strictly confidential (§23-6-17 Confidentiality, §23-6-18 Protection of Records). If you do not follow these guidelines, if you provide false information or withhold financial or other critical information or if we suspect you are using funds for the RI EOHHS Drug Assistance Program to which you are not entitled, you may be prosecuted, fined and/or terminated from RI EOHHS Drug Assistance Program.

By participating in the RI EOHHS Drug Assistance Program, I agree to the following:

1. I give permission to the RI EOHHS Drug Assistance Program staff (coordinator, program manager, administrator, eligibility technician) to contact:

- a. My pharmacist
- b. My case manager
- c. My employer (for employee contributions to COBRA)
- d. My current or past health care provider(s)
- e. Any other person that I have specifically given permission to contact.

If needed, RI EOHHS Drug Assistance Program may contact these people to maintain my participation in the program. RI EOHHS Drug Assistance Program staff may also contact any insurance companies (third party payers/administrators) to make sure I am covered and to answer any billing questions. RI EOHHS Drug Assistance Program may also contact any of the people in the above list when I leave the program, if necessary. This may be done to get information about my participation in the program.

2. I give permission for my enrollment application files to be reviewed by the following: a. EOHHS staff

- b. My case manager and/or health care provider
- c. Auditors or other individuals reviewing application files as required for program fiscal monitoring. Information

in your RI EOHHS Drug Assistance Program enrollment application files will be kept strictly confidential. Under no circumstances will any personal identifying information in my file be shared with any unauthorized individual.

3. I agree to notify RI EOHHS as soon as possible if any of this information changes. I need to report any other information that might change my eligibility for programs, including but not limited to a.

Employment status

- b. Income
- c. Residence and Mailing address if separate
- d. Access to insurance coverage/Medicaid status
- e. Citizenship status

4. My application may be rejected if I have provided false information.

5. RI EOHHS cannot provide payments or reimbursements directly to me for any reason.

6. I may be required to pay back any RI EOHHS Drug Assistance Program benefits received if I was not eligible for them.

7. RI EOHHS is not required to make retroactive payments for coverage before I was enrolled in the program or if my enrollment lapses.

8. It is my responsibility to re-apply (recertify) with the Drug Assistance Program every 6 months on or before my birth month and 6 months following. If I do not recertify, my drug assistance benefits will be terminated.

9. It is my responsibility to pick up medications prescribed to me. I understand if I do not adhere to medication(s) prescribed, my drug assistance benefits will be terminated.

10. The enrolled client in the RI ADAP and or RIFAB programs assume full responsibility for accurate statements and reliable backup documents. Any person who knowingly and with intent to deceive the RIADAP and/or the RIFAB by providing containing any materially false information (e.g., Financial

forms, proof of residency, etc) or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who in connection with such application or claim, who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report associated with this application/ recertification shall also be subject to a civil penalty.

