



Application for State-funded Assistance to Pay for Health Care Coverage

Directions: To receive help paying for your health insurance, please fill out this form and mail it to the address below. We will reimburse you for part of your monthly premium. The amount is based on your income and family size.

Name: _____

Address: _____

Date of birth: _____

Last 4-digits of Social Security number: _____

Name of health plan selected (silver plan): _____

Telephone number (day time): _____

I attest that the information on this form is true.

Name of person applying (signature)

Date

Mail this form to: EOHHS/Rite Share, Hazard Bldg., 74 West Rd., Cranston, RI 02920