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

Date :
Case Number :

How to Contact Us
Go Online: www.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 and PACE)

The eligibility of all Medicaid beneficiaries must be renewed every year. To renew your Medicaid coverage for long-term services and supports (LTSS), including if eligible through the Katie Beckett provision, we need to know if certain eligibility factors have changed in any way. These factors include:

- 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 and 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.
- 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 of a non-citizen LTSS beneficiary and/or a sponsor has changed since the date of the initial application or last renewal.

DIRECTIONS: Please carefully read the printed information that appears below and write-in all changes. Be sure to return YOUR entire renewal form, including this page. If you have an account, you can update this information online. If you choose to reply by mail, please write the information that has changed in the "Updated Information" column. IF NO INFORMATION IS PREPRINTED AND YOU ARE RETURNING THIS FORM, FILL-IN THE BOXES WITH "CURRENT INFORMATION".

For More information visit www.healthyrhode.ri.gov
Para más información visite www.healthyrhode.ri.gov
Para mais informações visite www.healthyrhode.ri.gov

Case #:

IF YOU HAVE CHANGES TO REPORT, provide the documentation requested and return with this form. Be sure to put your name and social security number at the top of any documents you send us. Be sure to provide your signature to consent for electronic verifications and attest to the truthfulness of your responses.

IF YOU HAVE NO CHANGES TO REPORT, check the box ☐ after the question and skip to the next section. Be sure to go to the last page and complete the "intent to return form", if it applies to you, provide your signature to consent for electronic verifications, and attest to the truthfulness of your responses.

This form must be returned by 01/01/2018. 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 01/31/2018.

For Katie Beckett Eligible Children:

- **Mail or Drop Off to**: EOHHS KATIE BECKETT UNIT, Executive Office of Health and Human Services (EOHHS), Hazard Bldg -- #074, 74 West Road - Ground Level, Cranston, Rhode Island 02920
- **Telephone Number:** (401) 462-0633
- **Fax Number:** 401-462-6353

For all other Medicaid LTSS Beneficiaries:

- **Mail to**: PO Box 8709 Cranston, RI 02920-8787. **Or**
- **Drop Off:** the form at your local DHS office. For office locations, visit www.dhs.ri.gov or call 1-855-MY-RI-DHS.
- **Online**: You can also go to your User Account on www.healthyrhode.ri.gov and make the changes.

All beneficiaries may go to your User Account on www.HealthSourceRI.com. Make the changes on the Renewal Form and upload copies of the requested documents.

Case #:

LTSS Renewal Form

Please carefully read this form and write-in all blank or changed information about the beneficiary. Be sure to return YOUR entire renewal form, including this page.

IF YOU ARE REPLYING BY MAIL AND:

1. THERE IS PRE-PRINTED INFORMATION IN THE BOX, please write the information that has changed in the “Updated Information” column.
2. THE BOXES ARE BLANK, please fill-in the blanks with your “current information"

Beneficiary's Contact Information

	Current Information	Updated Information
Primary Contact and Relationship to Beneficiary		
Mailing Address		
	Current Information	Updated Information
Address where LTSS Beneficiary Lives now		
	Current Information	Updated Information
Phone Number		
Email		
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 and the names and income of any spouse/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 this information.

Case #:

If the boxes are pre-printed, 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

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 resources have changed, has any new resources, 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: INCLUDES CASH ON HAND, SAVINGS AND CHECKING ACCOUNTS, CERTIFICATES OF DEPOSIT, STOCK, BONDS, TRUST FUNDS, OWNERSHIP OF A BUSINESS, ETC.

☐ Check if NO changes in resources to report.

Case #:

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		
	Other		

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.

Case #:

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.

Send copies of the front and back of all health insurance cards for these plans even if there are no changes

☐ Check if NO changes in health insurance coverage to report

Case #:

Health Insurance	Policy Holder's Name	Policy Number	Monthly Premium

For More information visit www.healthyrhode.ri.gov
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Para mais informações visite www.healthyrhode.ri.gov

Case #:

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; and that I intend to return to live in this real estate at an appropriate time in the future.

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.

Case #:

PENALTY WARNING		
"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.		
Signature of Client or Authorized Representative Date:		
Signature of Spouse or parent Date:	Signature of Department Witness Date:	
Signature of Guardian/Conservator/Holder of power of attorney Date:		
Telephone Number	( )	

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Case #:

State of Rhode Island

MEDICARE PREMIUM PAYMENT PROGRAM (MPPP) RENEWAL

The eligibility of all Medicare Premium Payment Program beneficiaries must be renewed every year. To renew your MPPP assistance need to know if certain eligibility factors have changed in anyway. These factors include:

- Income. Any changes in the income of the MPPP beneficiary and any spouse or dependents who are considered when determining eligibility.
- Resources. Any changes in the resources of the MPPP beneficiary and spouse/dependents included in the beneficiary's household.
- Address and living arrangement. If the MPPP 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 MPPP beneficiary has died, received a divorce, married someone else, or moved into or out of a house that is NOT counted as a resource.

DIRECTIONS: Please carefully read the printed information that appears below and write-in all changes. Be sure to return YOUR entire renewal form, including this page. If you have an account, you can update this information online. If you choose to reply by mail, please write the information that has changed in the "Updated Information" column. IF NO INFORMATION IS PREPRINTED AND YOU ARE RETURNING THIS FORM, FILL-IN THE BOXES WITH "CURRENT INFORMATION".

IF YOU HAVE CHANGES TO REPORT, provide the documentation requested and return with this form. Be sure to put your name and social security number at the top of any documents you send us. Be sure to provide your signature to consent for electronic verifications and attest to the truthfulness of your responses .

IF YOU HAVE NO CHANGES TO REPORT, check the box ☐ after the question and skip to the next section. Be sure to go to the last page and complete the "intent to return form", if it applies to you, provide your signature to consent for electronic verifications and attest to the truthfulness of your responses.

This form must be returned by 01/01/2018.If we do not receive this signed formed by that date, your MPPP eligibility will not be renewed and you will lose coverage on 01/31/2018 .

- **Mail to**: PO Box 8709 Cranston, RI 02920-8787 . **Or**
- **Drop Off:** the form at your local DHS office. For office locations, visit www.dhs.ri.gov or call 1-855-MY-RI-DHS.
- **Online**: You can also go to your User Account on www.healthyrhode.ri.gov and make the changes.

Or go to your User Account on www.HealthSourceRI.com. Make the changes on the Renewal Form and upload copies of the requested documents.

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Para mais informações visite www.healthyrhode.ri.gov

Case #:

MPPP Renewal Form

Please carefully read this form and write-in all blank or changed information about the beneficiary. Be sure to return YOUR entire renewal form, including this page.

IF YOU ARE REPLYING BY MAIL AND:

- THERE IS PRE-PRINTED INFORMATION IN THE BOX, please write the information that has changed in the "Updated Information" column.
- THE BOXES ARE BLANK, please fill-in the blanks with your "current information"

Beneficiary's Contact Information

	Current Information	Updated Information
Primary Contact and Relationship to Beneficiary		
Mailing Address		
	Current Information	Updated Information
Address where MPPP Beneficiary Lives now		
	Current Information	Updated Information
Phone Number		
Email		
	Current Information	Updated Information
Name of Authorized Representative		

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 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 pre-printed, 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 .

Case #:

Name	SSN	DOB	Relationship to Beneficiary	Income /Type

2. Resources

Since the MPPP 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 these MPPP 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: INCLUDES CASH ON HAND, SAVINGS AND CHECKING ACCOUNTS, CERTIFICATES OF DEPOSIT, STOCK, BONDS, TRUST FUNDS, OWNERSHIP OF A BUSINESS, ETC.

☐ Check if NO changes in resources to report.

Case #:

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 MPPP 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 and other supplemental plans; and Medicare, Tricare, and similar government plans.

☐ Check if NO changes in health insurance coverage to report

Case #:

Health Insurance	Policy Holder's Name	Policy Number	Monthly Premium

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Case #:

PENALTY WARNING		
"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.		
Signature of Client or Authorized Representative Date:		
Signature of Spouse or parent Date:	Signature of Department Witness Date:	
Signature of Guardian/Conservator/Holder of power of attorney Date:		
Telephone Number	( )	

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Case #:

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

For More information visit www.healthyrhode.ri.gov
Para más información visite www.healthyrhode.ri.gov
Para mais informações visite www.healthyrhode.ri.gov

Case #:

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, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. 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 Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may 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 complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at : **http://www.ascr.usda.gov/complaint_filing_cust.html** , 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** . This institution is an equal opportunity provider.

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 206 Elmwood Avenue, Providence, RI 02907 telephone number 415-8500 (for deaf/hearing impaired 1-800-745-6575 Voice; 1-800-745-5555 TTY, or 711). 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 206 Elmwood Avenue, Providence, RI 02907, telephone number (401) 415-8500 (for deaf/hearing impaired 1-800-745-6575 voice; TTY 711).

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