HealthSourceRI
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF HUMAN SERVICES

APPLICATION FOR

Health Care Coverage

(and to find out if you can get help with costs)

Use this application to see what health care coverage you qualify for:	• Free or low-cost health care coverage from Rhode Island Medical Assistance or the Children's Health Insurance Program (CHIP) • A new tax credit that can help you pay your health care premiums • Private Health Plans
Apply faster online:	**Apply faster online at www.healthsourceri.com, www.dhs.ri.gov or www.ohhs.ri.gov** This application has all of the questions that you will see online at our website. There are many pages that repeat, to accommodate larger families. Look for notes at the top of the sections, to see if you can skip the section.
Information you may need to apply:	• Social Security numbers • Birth dates • Passport, alien, or other immigration numbers for any legal immigrants who need health care coverage • Previous tax returns, income information for all adults and all minors under age 19 who are required to file a tax return • Information about health coverage available to your family • W-2 Forms • 1099 Forms • Current employer health insurance information, even if you are not covered by your employer's insurance plan
Why do we ask for so much information?	We need the following information in order to determine what health care coverage you are qualified for. We will keep the information you provide private as required by law.
Send your complete and signed application to:	HealthSource RI HZD Mailroom 74 West Road, Suite 900 Cranston, RI 02920-8413
Get help with this application:	• Online: www.healthsourceri.com, www.dhs.ri.gov or www.ohhs.ri.gov • Phone: Call the Customer Support Center at 1-855-609-3304 or 1-888-657-3173 (TTY) • In person: To find in-person application assistance visit www.healthsourceri.com, www.dhs.ri.gov or www.ohhs.ri.gov or visit 70 Royal Little Drive, Providence RI (Monday through Saturday 8:00 AM to 9:00 PM, Sundays 12:00 PM Noon to 6:00 PM)

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Definitions

HealthSource RI: HealthSource RI is the Rhode Island health benefits exchange. It is a new way for individuals, families and small businesses in Rhode Island to compare and enroll in health coverage and gain access to tax credits, and reduced cost-sharing. HealthSource RI can also provide information about and assistance with applications for public programs such as Rhode Island Medical Assistance. You have access to HealthSource RI online, by phone, or in person.

Premium: A premium is the amount you pay every month for your health insurance, whether you're healthy or sick.

QHP: QHP stands for Qualified Health Plan. That means it meets Rhode Island's standards for health insurance. All plans must cover doctor visits, hospital stays, prescriptions and mental health care.

Deductible: A deductible is the amount you owe for certain health care services before your health insurance begins to pay. For example, if your deductible is $1,000, and you need knee surgery, you pay the first $1,000 of the bill. After that, your health plan starts paying for the cost of your care.

APTC: APTC stands for Advance Premium Tax Credit. Depending on your income, you may be eligible for a federal tax credit to help with the cost of your health insurance premium. Instead of waiting to claim the credit when you file your taxes, you can take the credit "in advance" each month to help pay your monthly premium. An Advance Premium Tax Credit is paid directly to your insurance provider.

Cost-Sharing Reductions: Some Rhode Islanders will qualify for Cost-Sharing Reductions. These help you pay for the cost of going to the doctor or getting a health care service.

Minimum Essential Coverage: This is the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, Children's Health Insurance Plan (CHIP), TRICARE and other coverage that covers Essential Health Benefits.

Minimum Value Standard: A health plan meets the "minimum value standard" if the plan's share of the total benefit costs covered is no less than 60 percent of such costs. If you do not have access to any health coverage that meets the minimum value standard, you may be eligible for tax credits to help cover the cost of insurance.

Individual Responsibility Requirement: Starting in 2014, the individual shared responsibility requirement calls for each individual to have minimum essential health coverage (known as minimum essential coverage) for each month, qualify for an exemption, or make a payment when filing his or her federal income tax return.

Rhode Island Medical Assistance: Public health coverage programs for eligible Rhode Island residents. Rhode Island Medical Assistance is the name used in Rhode Island for Medicaid, the Children's Health Insurance Program (CHIP) and state-only funded health care programs.

Health Care Coverage Rights and Responsibilities

Your rights for all health coverage programs. HealthSource RI and the Rhode Island Executive Office of Health and Human Services (EOHHS) (the State Medicaid Agency) must:

Help you fill out all requested forms: You can contact HealthSource RI or EOHHS for assistance.

Provide interpreter or translator services at no cost to you when communicating with HealthSource RI or EOHHS.

In accordance with federal and state law and U.S. Department of Health and Human Services (HHS) policy, **this institution is prohibited from discrimination on the basis of race, color, national origin (limited English proficiency persons), age, sex, disability, religion, gender identity or political beliefs.** To file a complaint of discrimination, contact HHS. Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

Your responsibilities for all health coverage programs. You must:

SSN Disclosure. You must provide the Social Security number (SSN) for anyone in your household, including yourself, who applies for health coverage, including Rhode Island Medical Assistance , Advance Premium Tax Credits (APTC) and Cost Sharing Reductions (CSR), under Federal Law (45 CFR 155.305 and 42 CFR 435.910).

SSNs are used to check identity, citizenship, alien status and income as well as prevent fraud and verify health care claims. We also use SSN information with other federal and state agencies, including the Internal Revenue Service, to manage our programs and follow the law.

If requested by the agency, provide any information or proof needed to decide if you are eligible.

Report changes in income, family size or other application information as soon as possible.

Things you should know for all health coverage programs:

There are certain state and federal laws that govern the operation of HealthSource RI and EOHHS, your rights and responsibilities as a user of HealthSource RI and the coverage obtained through HealthSource RI or EOHHS. By filling out this application, you agree to comply with these laws and coverage obtained hereby.

The National Voter Registration Act of 1973 requires all states to provide voter registration assistance through their public assistance offices. Applying to register or declining to register to vote will not affect the services or benefits that you will be provided by this agency. You can register to vote at http://www.elections.ri.gov/voting/registration.php.

You may ask for an appeal if you disagree with an eligibility determination made that affects your eligibility for a health plan, tax subsidies, or cost-sharing reductions. Pursuant to the proposed new EOHHS Rule "Complaints and Hearings #0110," you may file an appeal of this determination and the matter will be heard by a hearing officer. You must file the appeal within 30 days of receiving the notice of action you wish to appeal. You may also have the opportunity to resolve the matter through an informal resolution process. You can find more information about the appeals process by visiting www.healthsourceri.com, www.dhs.ri.gov or www.ohhs.ri.gov or by calling the HealthSource RI Contact Center at 1-855-609-3304.

If the appeal is for a decision on Rhode Island Medical Assistance coverage, which is unresolved by a case review, you will be scheduled for an Administrative Hearing.

You may apply for support enforcement services through the Office of Child Support Services. To get an application for these services, go to http://www.cse.ri.gov/ or visit your local Office of Child Support Services office at 77 Dorrance St, Providence RI 02903.

Health Insurance Portability and Accountability Act (HIPAA) restrictions prevent us from discussing the health information of you or any member of your household with anyone, including an authorized representative, unless that individual has power of attorney or you have signed a consent form authorizing the disclosure of this information. This includes disclosure of mental health information, HIV, AIDS, STD test results, or treatment and chemical dependency services.

The information that you give HealthSource RI or EOHHS is subject to verification by federal and state officials. In order to review your Application and to determine whether you qualify for financial support, HealthSource RI and EOHHS must obtain confidential financial and other information from state and federal agencies. This process may also include follow-up contacts from agency staff.

Your wage and employment data will also be verified by HealthSource RI and EOHHS with the Rhode Island Department of Labor and Training. Granting this consent will help to simplify the application and determination process.

Your personal information will be protected as described in the HealthSource RI Privacy Policy which will be made available to you as part of this application process.

HealthSource RI and EOHHS are not responsible for administering your health insurance plan. Your health insurance carrier can provide you more information about your benefits.

If you have questions about the terms of your health insurance plan, including what benefits you are eligible for, out of pocket expenses under your plan, and making a benefit claim or appealing a denial of benefits, you should contact your health insurance carrier. If you are eligible for COBRA following the termination of any health insurance coverage, administering COBRA and providing you the required COBRA notices and election periods is your former employer's or issuer's responsibility.

Do not cancel any current insurance coverage or decline any COBRA benefits until you receive an approval letter and insurance policy, also known as insurance contract or certificate, from the insurance carrier you select. Make sure you understand and agree with the terms of the policy, pay special attention to the effective date, waiting periods, premium amount, benefits, limitations, exclusions, and riders.

Your rights for Rhode Island Medical Assistance only. EOHHS and HealthSource RI must:

Give you 30 days to provide information we need. If you don't give us the information or ask for more time we may deny, close, or change your health care coverage.

Notify you, in most cases, at least 10 days before we stop your health care coverage.

Give you a written decision, in most cases, within 30 days. Health care coverage and some disability cases may take 45 to 90 days.

Continue Rhode Island Medical Assistance coverage while we decide if you are eligible for another program.

Your responsibilities for Rhode Island Medical Assistance only. You must:

Report any changes to what you have reported on the application within 10 days of the change.

Cooperate with the Office of Child Support Services if you receive Rhode Island Medical Assistance coverage. You must help establish, modify, or enforce child support for the child(ren) in your care, and establish paternity (if necessary). If you can show that you have a good reason to believe that cooperating with the Office of Child Support Services puts you, your children, or the children in your care at risk of harm from the noncustodial parent, you may claim good cause not to cooperate.

Cooperate with Quality Assurance staff when asked.

Apply for and make a reasonable effort to get potential income from other sources when you ask for or receive Rhode Island Medical Assistance coverage.

Things you should know for Rhode Island Medical Assistance only:

By asking for and receiving Rhode Island Medical Assistance, you give the state of Rhode Island all rights to any medical support and to any third party payments for health care, including third party casualty insurance. When you receive Rhode Island Medical Assistance, you assign your medical support rights to the Office of Child Support Services.

If you stop getting Rhode Island Medical Assistance, you must tell Office of Child Support Services about any changes that affect medical support, such as if your child has moved or your address has changed.

By law (RI Gen Laws 40-8-15), if you are age 55 or older AND receive Rhode Island Medical Assistance services, Medicaid may recover from your estate (assets you own at the time of death) to repay Medicaid for the costs of health care assistance. This is called ESTATE RECOVERY. Tribal lands and certain properties belonging to American Indians and Alaskan Natives may be exempt from recovery. If you have dependent heirs, estate recovery may not apply or may be delayed for some hardship reasons.

Estate Recovery does not occur until after your death. Medicaid may recover the costs for state-only funded long-term care services received at any age.

You may be restricted to one health care provider, pharmacy, and/or hospital if you seek out unnecessary health care services from providers.

Things you should know for qualified health plans only:

If you enroll in a qualified health plan through HealthSource RI and you do not provide enough information for HealthSource RI to verify your eligibility to purchase a plan or receive a reduced-cost plan, or if any information you provide is not verifiable, you will have 90 days to provide further information to satisfy HealthSource RI's eligibility requirements. During this time, you should work with HealthSource RI staff to try to provide any missing information or resolve any inconsistencies so that your coverage and applicable costs may be effective as soon as possible.

If you enroll in a qualified health plan through HealthSource RI and you have a change in income, you should notify HealthSource RI as soon as possible. A change in income could change the tax credits or cost-sharing reductions for which you are eligible to help you pay for insurance. We base your tax credit on the income you put on this application. If your income goes up, you will qualify for less of a discount on your health coverage. If you don't tell us about your income changing, we will continue to offer the same discount every month but you will have to pay that money back at tax time.

For example, when Susan buys health insurance, she earns about $30,000 a year. She qualifies for a tax credit of $2,000. She decides to use it to reduce the monthly cost of her health insurance. She gets $166 off her bill every month. Six months later, she gets a new job and earns too much money to get a tax credit. If she doesn't tell anyone, she will continue to get $166 off her health insurance. At tax time, she will owe $166 for every month she didn't qualify for the credit.

Premium rates are subject to change based on the health insurance carrier's underwriting practices and your selection of available optional benefits, if any. Final rates are always determined by the health insurance carrier.

Premium rates are for your requested effective date ONLY. If the actual effective date of your policy is different from your requested effective date, the actual cost of your policy may differ from the rates listed on healthsourceri.com, due to rate increases or policy changes from the insurance company and/or one or more family members having a birthday. (Rates are highly dependent on age.) The carrier you selected may not guarantee their rates for any period of time until a contract is signed.

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Application for Health Care Coverage

About You and Your Family

Please include the following individuals on this application: yourself; your spouse; your unmarried partner who lives with you, but only if you have children together who need health coverage; your children and anyone else under 19 who you take care of and who lives with you; and anyone you include on your federal tax return, even if they don't live with you. Anyone else who lives with you will need to file their own application. You can complete an application for other people in your family even if you don't need coverage or are not eligible for coverage. You can skip the questions on SSNs for family members who are not applying for coverage.

Primary Applicant - We need one adult in the family to be the contact for the application

1. First Name | Middle Name | Last Name | Suffix (e.g. Jr., I, II etc.)

2. Gender ☐ M ☐ F

3. Date of Birth Month:_____ Day:_____ Year:_____

4. Are you applying for Medical coverage? ☐ Yes ☐ No

5. Are you applying for Dental coverage? ☐ Yes ☐ No

6. Do you have a Social Security number? ☐ Yes ☐ No

If you have an SSN, enter it here.

6a. Social Security number (SSN):_____

7. My Name is different on my Social Security card: ☐ Yes ☐ No

7a. If YES, Name on Card: _____

Family Member 2 – You can skip questions 13-14 if this person is not applying for health coverage

8. First Name | Middle Name | Last Name | Suffix (e.g. Jr., I, II etc.)

9. Gender ☐ M ☐ F

10. Date of Birth Month:_____ Day:_____ Year:_____

11. Is this person applying for Medical coverage? ☐ Yes ☐ No

12. Is this person applying for Dental coverage? ☐ Yes ☐ No

13. Does this person have a Social Security number? ☐ Yes ☐ No

If this person has an SSN, enter it here.

13a. Social Security number (SSN):_____

14. Is this person's name is different on my Social Security card:
☐ Yes ☐ No

14a. If YES, Name on Card: _____

Family Member 3 – You can skip questions 20-21 if this person is not applying for health coverage

15. First Name | Middle Name | Last Name | Suffix (e.g. Jr., I, II etc.)

16. Gender ☐ M ☐ F

17. Date of Birth Month:_____ Day:_____ Year:_____

18. Is this person applying for Medical coverage? ☐ Yes ☐ No

19. Is this person applying for Dental coverage? ☐ Yes ☐ No

20. Does this person have a Social Security number? ☐ Yes ☐ No

If this person has an SSN, enter it here.

20a. Social Security number (SSN):_____

21. Is this person's name is different on his or her Social Security card:
☐ Yes ☐ No

21a. If YES, Name on Card: _____

Family Member 4 – You can skip questions 27-28 if this person is not applying for health coverage

22. First Name | Middle Name | Last Name | Suffix (e.g. Jr., I, II etc.)

23. Gender ☐ M ☐ F

24. Date of Birth Month:_____ Day:_____ Year:_____

25. Is this person applying for Medical coverage? ☐ Yes ☐ No

26. Is this person applying for Dental coverage? ☐ Yes ☐ No

27. Does this person have a Social Security number? ☐ Yes ☐ No

If this person has an SSN, enter it here.

27a. Social Security number (SSN):_____

28. Is this person's name different on his or her Social Security card:
☐ Yes ☐ No

28a. If YES, Name on Card: _____

Photocopy this sheet to add additional family members.

Tell Us About Yourself – Primary Applicant

1. First Name	Middle Name	Last Name	Suffix (e.g. Jr., I, II etc.)

1a. Primary Phone Number	**1b.** Secondary Phone Number	**1c.** Email Address
☐ Cell ☐ Home ☐ Work ( )	☐ Cell ☐ Home ☐ Work ( )	

2. HealthSource RI may need to contact you regarding the status of your application and/or request additional information. What is your preferred method of contact? ☐ Email ☐ Paper Mail

3. What is your preferred time of contact for calls? ☐ Morning ☐ Afternoon ☐ Evening ☐ Weekend ☐ Anytime

4. Preferred spoken language (lengua hablada preferida)
☐ English ☐ Español ☐ Português

4a. Preferred written language (lenguaje escrito preferido)
☐ English ☐ Español ☐ Português

5. Home Address	Apt/Unit #	City	State	Zip Code
6. Mailing Address *(if different)*	Apt/Unit #	City	State	Zip Code

Your Additional Information

7. Ethnicity (Optional) ☐ Hispanic/Latino ☐ Non Hispanic/Latino

8. Race (Optional)
☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaskan Native
☐ Pacific Islander/Native Hawaiian ☐ Indian ☐ Other

9. Are you currently incarcerated? ☐ Yes ☐ No

9a. If YES: Expected Release Date: Month:_____ Day:_____ Year:_____

10. Are you pregnant? ☐ Yes ☐ No

10a. If YES: Pregnancy Due Date: Month:_____ Day:_____ Year:_____

10b. Number of babies expected:

Your Citizenship and Immigration Information

You don't need to answer questions 11-14 if you're not applying for coverage.

11. Immigration Status: (check one) ☐ U.S. Citizen/National ☐ Naturalized Citizen† ☐ Eligible Immigrant† ☐ Other

12. If a non-citizen, have you lived in the U.S. for any length of time prior to 08/22/1996? ☐ Yes ☐ No

13. †If you are NOT a U.S. Citizen or National or if you are a Naturalized Citizen, please provide information on your documentation.

Document Type		Document Number	Expiration(MM/DD/YY)
13a. Certificate of Citizenship: Alien #:	☐	Citizenship Number	Not applicable
13b. Naturalization Certificate: Alien #:	☐	Naturalization Number	Not applicable
13c. Reentry Permit (I-327): Alien #:	☐		
13d. Permanent Resident Card ("Green Card," I-551): Alien #:	☐	I-551 Number:	
13e. Refugee Travel Document (I-571) Alien #:	☐		
13f. Employment Authorization Card (I-766) Alien #:	☐		
13g. Machine Readable Immigrant Visa (with temporary I-551 language). Visa Number:_____ Country of Issuance: _____ Alien Number:_____	☐	Passport Number:	
13h. Temporary I-551 Stamp (on passport or I-94, I-94A) Country of Issuance: _____ Alien Number:_____	☐	Passport Number:	
13i. Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services Sevis ID: _____	☐	I-94 Number:	
13j. Arrival/Departure Record in unexpired foreign passport (I-94) Country of Issuance: _____ Sevis ID: _____ Visa Number: _____	☐	Passport Number: I-94 Number:	
13k. Unexpired foreign passport Country of Issuance: _____ Sevis ID: _____	☐	Passport Number: I-94 Number:	
13L. Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20) Sevis ID: _____	☐	Passport Number: I-94 Number:	
13m. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) Sevis ID: _____	☐	Passport Number: I-94 Number:	
13n. Other documents or status types Document Description:_____ Alien Number:_____ Sevis ID: _____	☐	Passport Number: I-94 Number:	

14. If your name is different on your immigration document, please provide the name on the document:

First Name	Middle Name	Last Name	Suffix (e.g. Jr., I, II etc.)

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Veteran's Information about You

15. Are you, your spouse or parent a veteran or an active duty member in the U.S. military? ☐ Yes ☐ No

Your American Indian & Alaskan Native Information

American Indian and Alaskan Natives may be eligible for special Rhode Island Medical Assistance protections and for special benefits through HealthSource RI.

16. Are you an American Indian or Alaskan Native? ☐ Yes ☐ No **If NO**, skip to question 18.

If YES: 17. Are you a member of a Federally Recognized Tribe? ☐ Yes ☐ No

If YES: 17a. Tribe Name **17b.** State

17c. Have you ever gotten services from an Indian health service, tribal program or urban Indian health program? ☐ Yes ☐ No

17d. Are you eligible to receive services from an Indian health service, tribal health program or urban Indian health program through a referral from one of these programs? ☐ Yes ☐ No

Your Disability and Disability Services Information

18. Are you physically ill, incapacitated, disabled or blind?	☐ Yes ☐ No
18a. Do you need help with the activities of daily living?	☐ Yes ☐ No
If YES:	
18b. Will this disability prevent you from working at least 12 months, or result in death?	☐ Yes ☐ No
18c. Are you active with the Office of Rehabilitation Services or Services for the Blind?	☐ Yes ☐ No
18d. Have you applied for Social Security Benefits (RSDI) or SSI?	☐ Yes ☐ No

Additional Questions about You

19. Were you in Rhode Island Foster Care on your 18th birthday?	☐ Yes ☐ No
20. If you are under 19 years old, are you a full time student? **If YES:** Expected Graduation Date:Month:_____ Day:_____ Year:_____	☐ Yes ☐ No

Your Current Job and Income

21. Are you currently self-employed? **If NO**, skip to question 22.	☐ Yes ☐ No
21a. If YES, type of work:	**21b.** Gross monthly Self-Employment Income: _____ (Include your self-employment expenses in the answer to question 25.)
22. Are you currently employed (other than self-employed)? **If NO**, skip to Question 24.	☐ Yes ☐ No

If you are currently employed, please complete the following information on your employer and income.

22a. Employer 1 Name:		**22b.** Employer Identification Number	
22c. Employer Address	City	State	Zip Code
22d. Wages/Tips before Taxes:		**22e.** Wages/Tips Frequency: ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly	**22f.** Average Number of hours you work each week

If you have another employer, please complete the following information on that employer and income.

23a. Employer 1 Name:		**23b.** Employer Identification Number	
23c. Employer Address	City	State	Zip Code
23d. Wages/Tips before Taxes:		**23e.** Wages/Tips Frequency: ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly	**23f.** Average Number of hours you work each week

Photocopy this sheet to add additional employers for the primary applicant

Your Other Income

24. Do you have other sources of Income? **If YES,** check all that apply. **If NO**, go to question 25.

NOTE: Do not include child support, non-pension veteran's payments, or Supplemental Security Income (SSI)

Sources		How much ($)	How often
24a. Social Security Benefits	☐		
24b. Unemployment	☐		
24c. Retirement	☐		
24d. Alimony Received	☐		
24e. Dividend Payments *Companies report this income to you on an IRS 1099-DIV form each year.*	☐		
24f. Capital Gains *These are profits from the sales of investments, such as stocks.*	☐		
24g. Pensions	☐		
24h. Farming/Fishing Income	☐		
24i. Rental or Royalty Income *This is monthly income from renting a property that wasn't included in self-employment.*	☐		
24j. Interest	☐		
24k. Investment	☐		
24L. Other income (cash support, etc.) *Type:*	☐		
24m. Other income *Type:*	☐		

Your Deductions

We ask these questions because these expenses can reduce the amount of income that we count for some kinds of health care coverage, just like the IRS uses them to reduce the amount of taxes you owe. Telling us about them could make the cost of health coverage a little lower.

Deductions are payments that can be subtracted from your total income.

Business deductions are the costs of running the business that must be paid before the business can declare a profit. Self-employment, rental/royalty income and farming/fishing income will have business deductions that should be **totaled and entered as one line below**. For more information on self-employment deductions, see "Instructions for Schedule C" at www.irs.gov.

25. List below any items that can be deducted on a federal income tax return. Allowable deductions include, but are not limited to, the following:

Alimony paid	Health savings account contributions	Self-employment deductions
Interest on student loans	Pre-tax retirement account contributions (excluding Roth IRA contributions)	Self-employment retirement plan
Tuition and school fees	Moving costs related to a job change	Self-employment health insurance premium

Deductions		How much ($)	How often
25a. Type:	☐		
25b. Type:	☐		
25c. Type:	☐		
25d. Type:	☐		

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Your American Indian/Alaskan Native Income

26. Has any income you reported come from any of these sources:

- Per capita payments from a tribe that came from natural resources, usage rights, leases
- Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian Trust Land by the Department of the Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

26a. If YES:	How much ($)	How often

Your Estimated Income for Next Year (optional)

27. If your income is not steady month to month, how much do you think you will make next year? $_____

Family Member 2 - Skip to page 23 if there is no one else in your family

1. First Name | M.I. | Last Name | Suffix (e.g. Jr., I, II etc.)

2. Does this person live with You, the Primary Applicant? ☐ Yes ☐ No

3. If NO, this person's Home Address	Apt/Unit #	City	State	Zip Code

4. Is this person living outside of Rhode Island temporarily? ☐ Yes ☐ No

5. Relationship to You, the Primary Applicant:

- ☐ Brother/sister
- ☐ Uncle/aunt
- ☐ First cousin
- ☐ Son-in-law/daughter-in-law
- ☐ Brother-in-law/sister-in-law
- ☐ Trustee
- ☐ Ward
- ☐ Non-relative caretaker
- ☐ Spouse
- ☐ Domestic Partner
- ☐ Former spouse
- ☐ Son/daughter
- ☐ Stepson/stepdaughter
- ☐ Nephew/niece
- ☐ Child of domestic partner
- ☐ Grandchild
- ☐ Adopted son/daughter
- ☐ Foster child
- ☐ Sponsored dependent
- ☐ Parent
- ☐ Stepparent
- ☐ Guardian
- ☐ Father-in-law/ mother-in-law
- ☐ Grandparent
- ☐ Parent's domestic partner

6. If Family Member 2 is under 18 years old, who is his or her primary caretaker? ☐ You (Primary Applicant)
☐ Family Member 3 (Name:_____) ☐ Family Member 4 (Name:_____)
☐ Other person not listed on this application

7. Ethnicity (Optional) ☐ Hispanic/Latino ☐ Non Hispanic/Latino

8. Race (Optional)
☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaskan Native
☐ Pacific Islander/Native Hawaiian ☐ Indian ☐ Other

9. Is this person currently incarcerated? ☐ Yes ☐ No
9a. If YES: Expected Release Date: Month:_____ Day:_____ Year:_____

10. Is this person pregnant? ☐ Yes ☐ No
10a. If YES: Pregnancy Due Date: Month:_____ Day:_____ Year:_____
10b. Number of babies expected:

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Family Member 2 - Citizenship and Immigration Information

You don't need to answer questions 11-14 if this person is not applying for coverage.

11. Immigration Status: (check one) ☐ U.S. Citizen/National ☐ Naturalized Citizen† ☐ Eligible Immigrant† ☐ Other

12. If a non-citizen, has this person lived in the U.S. for any length of time prior to 08/22/1996? ☐ Yes ☐ No

13. †If this person is NOT a U.S. Citizen or National or if s/he is a Naturalized Citizen, please provide information on documentation.

Document Type		Document Number	Expiration(MM/DD/YY)
13a. Certificate of Citizenship: Alien #:	☐	Citizenship Number	Not applicable
13b. Naturalization Certificate: Alien #:	☐	Naturalization Number	Not applicable
13c. Reentry Permit (I-327): Alien #:	☐		
13d. Permanent Resident Card ("Green Card," I-551): Alien #:	☐	I-551 Number:	
13e. Refugee Travel Document (I-571) Alien #:	☐		
13f. Employment Authorization Card (I-766) Alien #:	☐		
13g. Machine Readable Immigrant Visa (with temporary I-551 language). Visa Number:_____ Country of Issuance: _____ Alien Number:_____	☐	Passport Number:	
13h. Temporary I-551 Stamp (on passport or I-94, I-94A) Country of Issuance: _____ Alien Number:_____	☐	Passport Number:	
13i. Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services Sevis ID: _____	☐	I-94 Number:	
13j. Arrival/Departure Record in unexpired foreign passport (I-94) Country of Issuance: _____ Sevis ID: _____ Visa Number: _____	☐	Passport Number: I-94 Number:	
13k. Unexpired foreign passport Country of Issuance: _____ Sevis ID: _____	☐	Passport Number: I-94 Number:	
13L. Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20) Sevis ID: _____	☐	Passport Number: I-94 Number:	
13m. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) Sevis ID: _____	☐	Passport Number: I-94 Number:	
13n. Other documents or status types Document Description:_____ Alien Number:_____ Sevis ID: _____	☐	Passport Number: I-94 Number:	

14. If this person's name is different on his or her immigration document, please provide the name on the document:

First Name	Middle Name	Last Name	Suffix (e.g. Jr., I, II etc.)

Family Member 2 - Veteran's Information

15. Is this person, his or her spouse or parent a veteran or an active duty member in the U.S. military? ☐ Yes ☐ No

Family Member 2 - American Indian & Alaskan Native Information

American Indian and Alaskan Natives may be eligible for special Rhode Island Medical Assistance protections and for special benefits through HealthSource RI.

16. Is this person an American Indian or Alaskan Native? ☐ Yes ☐ No **If NO**, skip to question 18.

If YES:
17. Is this person a member of a Federally Recognized Tribe? ☐ Yes ☐ No
If YES: **17a.** Tribe Name _____ **17b.** State _____

17c. Has this person ever gotten services from an Indian health service, tribal program or urban Indian health program?
☐ Yes ☐ No

17d. Is this person eligible to receive services from an Indian health service, tribal health program or urban Indian health program through a referral from one of these programs? ☐ Yes ☐ No

Family Member 2 - Disabilities and Disability Services

18. Is this person physically ill, incapacitated, disabled or blind?	☐ Yes	☐ No
18a. Does this person need help with the activities of daily living?	☐ Yes	☐ No
If YES:		
18b. Will this disability prevent the person from working at least 12 months, or result in death?	☐ Yes	☐ No
18c. Is this person active with the Office of Rehabilitation Services or Services for the Blind?	☐ Yes	☐ No
18d. Has this person applied for Social Security Benefits (RSDI) or SSI?	☐ Yes	☐ No

Family Member 2 - Additional Questions

19. If this person is under 19 years old, is this person a full time student? **If YES**: Expected Graduation Date: Month:_____ Day:_____ Year:_____	☐ Yes	☐ No
20. If over 18 years of age, was this person in the Rhode Island Foster Care system on his or her 18th birthday?	☐ Yes	☐ No
Absentee Parent Information (Optional): This question only applies to applicants under the age of 18. **21.** Does this child have a parent living outside the home?	☐ Yes	☐ No

If YES, provide information on the parent living outside the home (Optional)

21a. First Name	M.I.	Last Name	Suffix (e.g. Jr., I, II etc.)
21b. Address	City	State	Zip Code
21c. Country	**21d.** SSN:		

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Family Member 2 - Current Job and Income

22. Is this person currently self-employed? **If NO**, skip to question 23.		☐ Yes ☐ No
22a. If YES, type of work:	**22b.** Gross monthly Self-Employment Income: _____ (Include your self-employment expenses in the answer to question 26.)	
23. Is this person currently employed (other than self-employed)?		☐ Yes ☐ No (**If NO,** skip to 25)
If this person is currently employed, please complete the following information on the employer and income.		
23a. Employer 1 Name:	**23b.** Employer Identification Number (EIN)	
23c. Employer Address City	State	Zip Code
23d. Wages/Tips before Taxes:	**23e.** Wages/Tips Frequency: ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly	**23f.** Average Number of hours Is this person works each week
24. If this person has another employer, please complete the following information on that employer and income.		
24a. Employer 1 Name:	**24b.** Employer Identification Number (EIN)	
24c. Employer Address City	State	Zip Code
24d. Wages/Tips before Taxes:	**24e.** Wages/Tips Frequency: ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly	**24f.** Average Number of hours this person works each week
Photocopy this page to add additional employers for family member 2.		

Family Member 2 - Other Income

25. Does this person have other sources of Income? **If YES**, check all that apply. **If NO**, go to question 26.

NOTE: Do not include child support, non-pension veteran's payments, or Supplemental Security Income (SSI)

Sources		How much ($)	How often
25a. Social Security Benefits	☐		
25b. Unemployment	☐		
25c. Retirement	☐		
25d. Alimony Received	☐		
25e. Dividend Payments *Companies report this income to you on an IRS 1099-DIV form each year.*	☐		
25f. Capital Gains *These are profits from the sales of investments, such as stocks.*	☐		
25g. Pensions	☐		
25h. Farming/Fishing Income	☐		
25i. Rental or Royalty Income *This is monthly income from renting a property that wasn't included in self-employment.*	☐		
25j. Interest	☐		
25k. Investment	☐		
25L. Other income (cash support, etc.) *Type:*	☐		
25m. Other income *Type:*	☐		

Family Member 2 - Deductions

We ask these questions because these expenses can reduce the amount of income that we count for some kinds of health care coverage, just like the IRS uses them to reduce the amount of taxes you owe. Telling us about them could make the cost of health coverage a little lower.

Deductions are payments that can be subtracted from your total income.

Business deductions are the costs of running the business that must be paid before the business can declare a profit. Self-employment, rental/royalty income and farming/fishing income will have business deductions that should be **totaled and entered as one line below**. For more information on self-employment deductions, see "Instructions for Schedule C" at www.irs.gov.

26. List below any items that can be deducted on a federal income tax return. Allowable deductions include, but are not limited to, the following:

Alimony paid	Health savings account contributions	Self-employment deductions
Interest on student loans	Pre-tax retirement account contributions (excluding Roth IRA contributions)	Self-employment retirement plan
Tuition and school fees	Moving costs related to a job change	Self-employment health insurance premium

Deductions		How much ($)	How often
26a. Type:	☐		
26b. Type:	☐		
26c. Type:	☐		
26d. Type:	☐		

Family Member 2 - American Indian/Alaskan Native Income

27. Has any income reported for this person come from any of these sources:

- Per capita payments from a tribe that came from natural resources, usage rights, leases
- Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian Trust Land by the Department of the Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

27a. If YES: How much ($) How often

Family Member 2 - Estimated Income for Next Year (optional)

28. If this person's income is not steady month to month, what is his or her estimated income next year? $_____

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Family Member 3 - Skip to page 23 if there is no one else in your family

1. First Name | M.I. | Last Name | Suffix (e.g. Jr., I, II etc.)

2. Does this person live with You, the Primary Applicant? ☐ Yes ☐ No

3. If NO, this person's Home Address	Apt/Unit #	City	State	Zip Code

4. Is this person living outside of Rhode Island temporarily? ☐ Yes ☐ No

5. Relationship to You, the Primary Applicant:

☐ Brother/sister	☐ Spouse	☐ Son/daughter	☐ Parent
☐ Uncle/aunt	☐ Domestic Partner	☐ Stepson/stepdaughter	☐ Stepparent
☐ First cousin	☐ Former spouse	☐ Nephew/niece	☐ Guardian
☐ Son-in-law/daughter-in-law		☐ Child of domestic partner	☐ Father-in-law/ mother-in-law
☐ Brother-in-law/sister-in-law		☐ Grandchild	☐ Grandparent
☐ Trustee		☐ Adopted son/daughter	☐ Parent's domestic partner
☐ Ward		☐ Foster child	
☐ Non-relative caretaker		☐ Sponsored dependent	

6. If Family Member 3 is under 18 years old, who is his or her primary caretaker? ☐ You (Primary Applicant)
☐ Family Member 2 (Name:_____) ☐ Family Member 4 (Name:_____)
☐ Other Person not listed on this application

7. Ethnicity (Optional) ☐ Hispanic/Latino ☐ Non Hispanic/Latino

8. Race (Optional)
☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaskan Native
☐ Pacific Islander/Native Hawaiian ☐ Indian ☐ Other

9. Is this person currently incarcerated? ☐ Yes ☐ No
9a. If YES: Expected Release Date: Month:_____ Day:_____ Year:_____

10. Is this person pregnant? ☐ Yes ☐ No

10a. If YES: Pregnancy Due Date: Month:_____ Day:_____ Year:_____
10b. Number of babies expected:

Family Member 3 - Citizenship and Immigration Information

You don't need to answer questions 11-14 if this person is not applying for coverage.

11. Immigration Status: (check one) ☐ U.S. Citizen/National ☐ Naturalized Citizen† ☐ Eligible Immigrant† ☐ Other

12. If a non-citizen, has this person lived in the U.S. for any length of time prior to 08/22/1996? ☐ Yes ☐ No

13. †If this person is NOT a U.S. Citizen or National or if s/he is a Naturalized Citizen, please provide information on documentation.

Document Type		Document Number	Expiration(MM/DD/YY)
13a. Certificate of Citizenship: Alien #:	☐	Citizenship Number	Not applicable
13b. Naturalization Certificate: Alien #:	☐	Naturalization Number	Not applicable
13c. Reentry Permit (I-327): Alien #:	☐		
13d. Permanent Resident Card ("Green Card," I-551): Alien #:	☐	I-551 Number:	
13e. Refugee Travel Document (I-571) Alien #:	☐		
13f. Employment Authorization Card (I-766) Alien #:	☐		
13g. Machine Readable Immigrant Visa (with temporary I-551 language). Visa Number:_____ Country of Issuance: _____ Alien Number:_____	☐	Passport Number:	
13h. Temporary I-551 Stamp (on passport or I-94, I-94A) Country of Issuance: _____ Alien Number:_____	☐	Passport Number:	
13i. Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services Sevis ID: _____	☐	I-94 Number:	
13j. Arrival/Departure Record in unexpired foreign passport (I-94) Country of Issuance: _____ Sevis ID: _____ Visa Number: _____	☐	Passport Number: I-94 Number:	
13k. Unexpired foreign passport Country of Issuance: _____ Sevis ID: _____	☐	Passport Number: I-94 Number:	
13L. Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20) Sevis ID: _____	☐	Passport Number: I-94 Number:	
13m. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) Sevis ID: _____	☐	Passport Number: I-94 Number:	
13n. Other documents or status types Document Description:_____ Alien Number:_____ Sevis ID: _____	☐	Passport Number: I-94 Number:	

14. If this person's name is different than on his or her immigration document, please provide the name on the document:

First Name	Middle Name	Last Name	Suffix (e.g. Jr., I, II etc.)

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Family Member 3 - Veteran's Information

15. Is this person, his or her spouse or parent a veteran or an active duty member in the U.S. military? ☐ Yes ☐ No

Family Member 3 - American Indian & Alaskan Native Information

American Indian and Alaskan Natives may be eligible for special Rhode Island Medical Assistance protections and for special benefits through HealthSource RI.

16. Is this person an American Indian or Alaskan Native? ☐ Yes ☐ No **If NO**, skip to question 18.

If YES:
17. Is this person a member of a Federally Recognized Tribe? ☐ Yes ☐ No
If YES: **17a.** Tribe Name _____ **17b.** State _____

17c. Has this person ever gotten services from an Indian health service, tribal program or urban Indian health program?
☐ Yes ☐ No

17d. Is this person eligible to receive services from an Indian health service, tribal health program or urban Indian health program through a referral from one of these programs? ☐ Yes ☐ No

Family Member 3 - Disabilities and Disability Services

18. Is this person physically ill, incapacitated, disabled or blind?	☐ Yes	☐ No
18a. Does this person need help with the activities of daily living?	☐ Yes	☐ No
If YES:		
18b. Will this disability prevent the person from working at least 12 months, or result in death?	☐ Yes	☐ No
18c. Is this person active with the Office of Rehabilitation Services or Services for the Blind?	☐ Yes	☐ No
18d. Has this person applied for Social Security Benefits (RSDI) or SSI?	☐ Yes	☐ No

Family Member 3 - Additional Questions

19. If this person is under 19 years old, is this person a full time student? **If YES**: Expected Graduation Date: Month:_____ Day:_____ Year:_____	☐ Yes	☐ No
20. If over 18 years of age, was this person in the Rhode Island Foster Care system on his or her 18th birthday?	☐ Yes	☐ No
Absentee Parent Information (Optional): This question only applies to applicants under the age of 18. **21.** Does this child have a parent living outside the home?	☐ Yes	☐ No

If YES, provide information on the parent living outside the home (Optional)

21a. First Name	M.I.	Last Name	Suffix (e.g. Jr., I, II etc.)
21b. Address	City	State	Zip Code
21c. Country	**21d.** SSN:		

If Family Member 3 has income, use pages Appendix A on pages 29-31 (make copies for other family members if necessary) to enter their complete income information.

Family Member 4 - Skip to page 23 if there is no one else in your family

1. First Name | M.I. | Last Name | Suffix (e.g. Jr., I, II etc.)

2. Does this person live with You, the Primary Applicant? ☐ Yes ☐ No

3. If NO, this person's Home Address | Apt/Unit # | City | State | Zip Code

4. Is this person living outside of Rhode Island temporarily? ☐ Yes ☐ No

5. Relationship to You, the Primary Applicant:

- ☐ Brother/sister
- ☐ Uncle/aunt
- ☐ First cousin
- ☐ Son-in-law/daughter-in-law
- ☐ Brother-in-law/sister-in-law
- ☐ Trustee
- ☐ Ward
- ☐ Non-relative caretaker
- ☐ Spouse
- ☐ Domestic Partner
- ☐ Former spouse
- ☐ Son/daughter
- ☐ Stepson/stepdaughter
- ☐ Nephew/niece
- ☐ Child of domestic partner
- ☐ Grandchild
- ☐ Adopted son/daughter
- ☐ Foster child
- ☐ Sponsored dependent
- ☐ Parent
- ☐ Stepparent
- ☐ Guardian
- ☐ Father-in-law/ mother-in-law
- ☐ Grandparent
- ☐ Parent's domestic partner

6. If Family Member 4 is under 18 years old, who is his or her primary caretaker? ☐ You (Primary Applicant)
☐ Family Member 2 (Name:_____) ☐ Family Member 3 (Name:_____)
☐ Other Person not listed on this application

7. Ethnicity (Optional) ☐ Hispanic/Latino ☐ Non Hispanic/Latino

8. Race (Optional)
☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaskan Native
☐ Pacific Islander/Native Hawaiian ☐ Indian ☐ Other

9. Is this person currently incarcerated? ☐ Yes ☐ No
9a. If YES: Expected Release Date: Month:_____ Day:_____ Year:_____

10. Is this person pregnant? ☐ Yes ☐ No
10a. If YES: Pregnancy Due Date: Month:_____ Day:_____ Year:_____
10b. Number of babies expected:

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Family Member 4 - Citizenship and Immigration Information

You don't need to answer questions 11-14 if this person is not applying for coverage.

11. Immigration Status: (check one) ☐ U.S. Citizen/National ☐ Naturalized Citizen† ☐ Eligible Immigrant† ☐ Other

12. If a non-citizen, has this person lived in the U.S. for any length of time prior to 08/22/1996? ☐ Yes ☐ No

13. †If this person is NOT a U.S. Citizen or National or if s/he is a Naturalized Citizen, please provide information on documentation.

Document Type		Document Number	Expiration(MM/DD/YY)
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13b. Naturalization Certificate: Alien #:	☐	Naturalization Number	Not applicable
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13d. Permanent Resident Card ("Green Card," I-551): Alien #:	☐	I-551 Number:	
13e. Refugee Travel Document (I-571) Alien #:	☐		
13f. Employment Authorization Card (I-766) Alien #:	☐		
13g. Machine Readable Immigrant Visa (with temporary I-551 language). Visa Number:_____ Country of Issuance: _____ Alien Number:_____	☐	Passport Number:	
13h. Temporary I-551 Stamp (on passport or I-94, I-94A) Country of Issuance: _____ Alien Number:_____	☐	Passport Number:	
13i. Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services Sevis ID: _____	☐	I-94 Number:	
13j. Arrival/Departure Record in unexpired foreign passport (I-94) Country of Issuance: _____ Sevis ID: _____ Visa Number: _____	☐	Passport Number: I-94 Number:	
13k. Unexpired foreign passport Country of Issuance: _____ Sevis ID: _____	☐	Passport Number: I-94 Number:	
13L. Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20) Sevis ID: _____	☐	Passport Number: I-94 Number:	
13m. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) Sevis ID: _____	☐	Passport Number: I-94 Number:	
13n. Other documents or status types Document Description:_____ Alien Number:_____ Sevis ID: _____	☐	Passport Number: I-94 Number:	

14. If this person's name is different on his or her immigration document, please provide the name on the document:

First Name	Middle Name	Last Name	Suffix (e.g. Jr., I, II etc.)

Family Member 4 - Veteran's Information

15. Is this person, his or her spouse or parent a veteran or an active duty member in the U.S. military? ☐ Yes ☐ No

Family Member 4 - American Indian & Alaskan Native Information

American Indian and Alaskan Natives may be eligible for special Rhode Island Medical Assistance protections and for special benefits through HealthSource RI.

16. Is this person an American Indian or Alaskan Native? ☐ Yes ☐ No **If NO**, skip to question 18.

If YES:
17. Is this person a member of a Federally Recognized Tribe? ☐ Yes ☐ No
If YES: **17a.** Tribe Name _____ **17b.** State _____

17c. Has this person ever gotten services from an Indian health service, tribal program or urban Indian health program?
☐ Yes ☐ No

17d. Is this person eligible to receive services from an Indian health service, tribal health program or urban Indian health program through a referral from one of these programs? ☐ Yes ☐ No

Family Member 4 - Disabilities and Disability Services

18. Is this person physically ill, incapacitated, disabled or blind?	☐ Yes	☐ No
18a. Does this person need help with the activities of daily living?	☐ Yes	☐ No
If YES:		
18b. Will this disability prevent the person from working at least 12 months, or result in death?	☐ Yes	☐ No
18c. Is this person active with the Office of Rehabilitation Services or Services for the Blind?	☐ Yes	☐ No
18d. Has this person applied for Social Security Benefits (RSDI) or SSI?	☐ Yes	☐ No

Family Member 4 - Additional Questions

19. If this person is under 19 years old, is this person a full time student? **If YES**: Expected Graduation Date: Month:_____ Day:_____ Year:_____	☐ Yes	☐ No
20. If over 18 years of age, was this person in the Rhode Island Foster Care system on his or her 18th birthday?	☐ Yes	☐ No
Absentee Parent Information (Optional): This question only applies to applicants under the age of 18. **21.** Does this child have a parent living outside the home?	☐ Yes	☐ No

If YES, provide information on the parent living outside the home (Optional)

21a. First Name	M.I.	Last Name	Suffix (e.g. Jr., I, II etc.)	
21b. Address	City		State	Zip Code
21c. Country			**21d.** SSN:	

If Family Member 4 has income, use Appendix A on pages 29-31 (make copies for other family members if necessary) to enter their complete income information.

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Tax Filing Information – *Fill this out for all family members*

1. Does anyone in the family plan to file a Federal tax return next year? ☐ Yes ☐ No

If YES, please answer the following questions about taxes for family members on this application. **If NO**, go to page 24.

2. Expected Tax Filing Status for the Current Calendar Year

2a. Name of Tax Filer	**2b.** If Filing Jointly – Name of Spouse

3. Will any of the persons listed on the application claim any dependents on their tax return? ☐ Yes ☐ No

If YES, list tax filer and list dependents.

A dependent can be claimed by only one tax filer. For joint filers, you need to list dependents for the tax filer who will sign the tax form.

3a. Name of Tax Filer	**3b.** Name of Dependents

You don't need to complete the table below if the dependent is already listed above.

4. Will anyone in the family be a dependent on someone else's return (someone not already on the application)? ☐ Yes ☐ No

If YES, Please list all dependents who will be on someone else's return.

4a. Name of Dependent	**4b.** Name of Tax Filer	**4c.** Relationship of Dependent to Tax Filer

Health Coverage Information – Fill this out for all family members applying for coverage

1. Are you or anyone you are applying for (or will in the next 3 months) eligible for health insurance coverage from a job, even if it's from another person's job, like a spouse? ☐ Yes ☐ No

If YES, please provide the information in the table below. **If NO**, go to page 25.

2. Employer Name	**2a. Employer Identification Number (look on the employee's W-2)**	**2b. Employer Phone Number**

2c. Employer Address	City	State	Zip Code

3. Who can we contact at your job about employee coverage? Contact Name:	**3a.** Contact Phone number (primary)	**3b.** Contact Phone number (other)

3c. Contact Email:

4. Name of person eligible for this employer insurance on this application:

4a. Enrollment Status		**4b. Upcoming Changes to Your Plan**
☐ Enrolled Now ☐ Expect coverage to start ☐ Not Enrolled	Start Date (MM/DD/YYYY) _____	☐ Expect coverage to end on (MM/DD/YYYY)_____ ☐ Will Become Eligible on (MM/DD/YYYY)_____

5. Name of person eligible for this employer insurance on this application:

5a. Enrollment Status		**5b. Upcoming Changes to Your Plan**
☐ Enrolled Now ☐ Expect coverage to start ☐ Not Enrolled	Start Date (MM/DD/YYYY) _____	☐ Expect coverage to end on (MM/DD/YYYY)_____ ☐ Will Become Eligible on (MM/DD/YYYY)_____

6. Name of person eligible for this employer insurance on this application:

6a. Enrollment Status		**6b. Upcoming Changes to Your Plan**
☐ Enrolled Now ☐ Expect coverage to start ☐ Not Enrolled	Start Date (MM/DD/YYYY) _____	☐ Expect coverage to end on (MM/DD/YYYY)_____ ☐ Will Become Eligible on (MM/DD/YYYY)_____

7. Name of person eligible for this employer insurance on this application:

7a. Enrollment Status		**7b. Upcoming Changes to Your Plan**
☐ Enrolled Now ☐ Expect coverage to start ☐ Not Enrolled	Start Date (MM/DD/YYYY) _____	☐ Expect coverage to end on (MM/DD/YYYY)_____ ☐ Will Become Eligible on (MM/DD/YYYY)_____

8. Who is the employee for this employer insurance?

Employee First Name Employee M.I. Employee Last Name Suffix

9. What is the cost of the employer's lowest cost plan offered for a single employee (does not cover families) that meets the minimum value standard (see definition on page 2)? (Note: We need to know the cost of this plan even if you are not enrolled in it. You can get this information from your employer. If the employer offers wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation program, and didn't receive any other discounts based on wellness programs.)

Employee Premium: $_____ Frequency of Premium (weekly, monthly, yearly)_____

Photocopy this page to add insurance provided by other employers or other persons covered

Dental Coverage – Fill this out for all family members applying for coverage

10. Does anyone on this application have access to dental coverage? ☐ Yes ☐ No **If NO,** go to question 11.

10a. If YES, Please identify all of the family members who have access to dental coverage. **If your family has access to more than one type of insurance, photocopy this page and provide information on each insurance provider separately.**

Name _____

Name _____

Name _____

Name _____

10b. Name of Dental Insurance Company	**10c.** Policy Number	**10d.** Group Number

10e. Type of coverage ☐ Individual ☐ Family

Photocopy this page to add other dental insurance providers or other persons covered

Other Health Coverage – Fill this out for all family members applying for coverage

11. Is anyone on this application enrolled in other non-public health insurance? ☐ Yes ☐ No

11a. If YES, please indicate which is applicable. ☐ COBRA ☐ Retiree Plan

11b. Please identify which family members have access to this insurance.

Name _____

Name _____

Name _____

Name _____

11c. Please identify which family members are enrolled in this insurance.

Name _____

Name _____

Name _____

Name _____

12. Is anyone on this application enrolled in other health coverage? ☐ Yes ☐ No

12a. If YES, please select ONE. **If anyone in your family is enrolled in more than one type of insurance, photocopy this page and provide information on each insurance provider separately.** ☐ Veteran's Coverage ☐ CHIP ☐ Medicaid ☐ Peace Corps ☐ Medicare ☐ Americorps ☐ Tricare (don't check if you have Direct Care or Line of Duty) ☐ Private/Other

12b. If you have other Private Insurance, please provide the following information:

Name of Plan	**Policy Number**	**Group Number**

12c. Please identify which family members have access to this insurance.

Name _____

Name _____

Name _____

Name _____

12d. Please identify which family members are enrolled in this insurance.

Name _____

Name _____

Name _____

Name _____

Photocopy this page to add other insurance providers or other persons covered

Authorized Representative Information

An Authorized Representative is someone who is helping you get health coverage. This can be a relative or a friend. You have given them permission to see your personal information and to make decisions about your health coverage. By designating an authorized representative, you are giving permission for your authorized representative to:

- Sign the application on your behalf;
- Receive notices related to your application and account; and
- Act on your behalf for all matters related to the application and account.

If you ever need to change your authorized representative, contact HealthSource RI at 1-855-609-3304.

1. Do you have an authorized representative? ☐ Yes ☐ No

If YES, please answer the following questions:

1a. Authorized Representative's First Name, Middle Name, Last Name & Suffix (e.g. Jr., I, II etc.)

1b. Primary Phone Number ☐ Cell ☐ Home ☐ Work ( )	**1c.** Secondary Phone Number ☐ Cell ☐ Home ☐ Work ( )	**1d.** Email Address

1e. HealthSource RI may need to contact you regarding the status of the application and/or request additional information. Authorized Representative's preferred method of contact ☐ Email ☐ Paper Mail

1f. What is the preferred time of contact (for phone calls)? ☐ Morning ☐ Afternoon ☐ Evening ☐ Weekend ☐ Anytime

1g. Preferred spoken language (**lengua hablada preferida**) ☐ English ☐ Español ☐ Português	**1h.** Preferred written language **(lenguaje escrito preferido)** ☐ English ☐ Español ☐ Português

1i. Mailing Address	Apt/Unit #	City	State	Zip Code

1j. Company Name (If Applicable)	**1k.** Organization ID (If Applicable)

1L. The **Primary Applicant** must sign below to acknowledge that they have an authorized representative who can make decisions on their behalf.

Signature X_____

For Certified Application Counselors, Navigators, Agents, and Brokers Only

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

2. Application start date (MM/DD/YYYY)

2a. First name	Middle Name	Last Name	Suffix (e.g. Jr., I, II etc.)

2b. Organization name	**2c.** ID number (if applicable)

Read Carefully Before Signing

YOUR CONSENT FOR ACCESS TO AND SHARING OF ELECTRONIC DATA

You have applied for participation in the Rhode Island Health Benefits Exchange ("Exchange"). In order to review your Application and to determine whether you qualify for financial support, the Exchange has to obtain confidential financial and other information from state and federal agencies. By selecting the "I Agree" box below, 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, the U.S. Internal Revenue Service, Social Security Administration and the Department of Homeland Security.

If you do not select "I Agree" below, we will not refuse you any benefits or access to any programs for which you are eligible, however, we may not be able to assist you in accessing those programs if we do not obtain the information needed to determine your eligibility.

You can proceed to shop for and purchase health insurance coverage without selecting "I Agree," but if you would like to know whether you are eligible for any financial support for the purchase of coverage or whether you are eligible for publicly-funded coverage or other programs and supports, it will be necessary for you to select "I Agree."

The sharing and use of your information that you are authorizing by selecting "I Agree" below will comply 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 (known as HIPAA); The R.I. Confidentiality of Health Care Communications and Information Act (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, 26 U.S.C. 6103 and all other applicable laws and regulations.

By selecting "I Agree" below, I authorize the Exchange and/or Medicaid to obtain and to use confidential information about me from the state and federal agencies listed above and any others necessary to determine my eligibility for enrollment in publicly-funded health insurance coverage or other publicly-funded programs administered through this Site, and, if I am eligible, to coordinate benefits and payments and to confirm my continuing eligibility. To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow HealthSource RI to use income data, including information from tax returns for the next coverage year (2015). HealthSource RI will send me a notice, let me make changes, and I can opt out at any time.

☐ I Agree

☐ I do not agree and wish to proceed to submit an application for and purchase health insurance without checking my eligibility for other programs and supports

I understand that I may change my consent at any time through HealthSource RI and/or Medicaid. ☐ Yes ☐ No

I have read or had explained to me my rights and responsibilities and received a copy of the HealthSource RI *Rights and Responsibilities* (listed on pages 3-5 of this application). ☐ Yes ☐ No

Read Carefully Before Signing

TAX IMPLICATIONS OF INSURANCE AFFORDABILITY PROGRAMS, AND YOUR CONSENT FOR HEALTHSOURCE RI TO USE TAX INFORMATION

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow HealthSource RI to use income data, including information from tax returns for the next coverage year (2015). HealthSource RI will send me a notice, let me make changes, and I can opt out at any time.

I understand that if advance payments of the premium tax credit will be paid on my behalf to reduce the cost of health coverage for myself and/or my dependents:

- I must file a federal income tax return the year after my coverage year for the tax year in which I received coverage.
- If I'm married at the end of the coverage year, I must file a joint income tax return with my spouse.

I also expect that:

No one else will be able to claim me as a dependent on their coverage year federal income tax return.

I'll claim a personal exemption deduction on my coverage year federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through this Marketplace and whose premium for coverage is paid in whole or in part by advance payments.

If any of the above changes, I understand that it may impact my ability to get an advance premium tax credit.

I also understand that when I file my coverage year federal income tax return, the Internal Revenue Service (IRS) will compare the income on my tax return with the income on my application. I understand that if the income on my tax return is lower than the amount of income on my application, I may be eligible to get an additional tax credit amount. On the other hand, if the income on my tax return is higher than the amount of income on my application, I may owe additional federal income tax.

Declaration and Signature

I have read and understood the information in this application. I certify under penalty of perjury that my answers are correct, including information about citizenship and lien status, and complete to the best of my knowledge and belief. I know that under the state of Rhode Island General Laws, Section 40-6-15, a maximum fine of $1,000, or imprisonment of up to five (5) years, or both, may be imposed for a person who obtains or attempts to obtain, or aids or abets any person to obtain, public assistance to which s/he is not entitled or who willfully fails to report income, resources, or personal circumstances or increases therein which exceed the amount previously reported.

Under penalty of perjury, I attest to the identity of the minor children identified herein and that all of the information contained in this application is true. I understand that I am breaking the law if I give wrong information and can be punished under federal law, state law or both.

Signature	**Date**
Spouse's Signature	**Date**

APPENDIX A

Additional Income Information (If necessary)

Use these pages if you need more space to include income information for other family members, unless you have already provided this information. (Make copies if you need to add income information for more than one family member.)

Current Job and Income		
1. Is this person currently self-employed?	☐ Yes ☐ No	
1a. If YES, type of work:	**1b.** Gross monthly Self-Employment Income: _____ (Include your self-employment expenses in the answer to question 5.)	
2. Is this person currently employed (other than self-employed)?	☐ Yes ☐ No	
If this person is currently employed, please complete the following information on your employer and income.		
2a. Employer 1 Name:	**2b.** Employer Identification Number	
2c. Employer Address City	State	Zip Code
2d. Wages/Tips before Taxes:	**2e.** Wages/Tips Frequency: ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly	**2f.** Average Number of hours Is this person works each week
If this person has another employer, please complete the following information on that employer and income.		
3a. Employer 2 Name:	**3b.** Employer Identification Number	
3c. Employer Address City	State	Zip Code
3d. Wages/Tips before Taxes:	**3e.** Wages/Tips Frequency: ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly	**3f.** Average Number of hours Is this person works each week

Photocopy this page to add additional employers for this family member.

Other Income

4. Do this person have other sources of Income? **If YES**, check all that apply. **If NO**, go to question 5.

NOTE: Do not include child support, non-pension veteran's payments, or Supplemental Security Income (SSI)

Sources	How much ($)	How often
4a. Social Security Benefits ☐		
4b. Unemployment ☐		
4c. Retirement ☐		
4d. Alimony Received ☐		
4e. Dividend Payments ☐ *Companies report this income to you on an IRS 1099-DIV form each year.*		
4f. Capital Gains ☐ *These are profits from the sales of investments, such as stocks.*		
4g. Pensions ☐		
4h. Farming/Fishing Income ☐		
4i. Rental or Royalty Income ☐ *This is monthly income from renting a property that wasn't included in self-employment.*		
4j. Interest ☐		
4k. Investment ☐		
4L. Other income (cash support, etc.) *Type:* ☐		
4m. Other income *Type:* ☐		

Deductions

We ask these questions because these expenses can reduce the amount of income that we count for some kinds of health care coverage, just like the IRS uses them to reduce the amount of taxes you owe. Telling us about them could make the cost of health coverage a little lower.

Deductions are payments that can be subtracted from your total income.

Business deductions are the costs of running the business that must be paid before the business can declare a profit. Self-employment, rental/royalty income and farming/fishing income will have business deductions that should be **totaled and entered as one line below**. For more information on self-employment deductions, see "Instructions for Schedule C" at www.irs.gov.

5. List below any items that can be deducted on a federal income tax return. Allowable deductions include, but are not limited to, the following:

Alimony paid	Health savings account contributions	Self-employment deductions
Interest on student loans	Pre-tax retirement account contributions (excluding Roth IRA contributions)	Self-employment retirement plan
Tuition and school fees	Moving costs related to a job change	Self-employment health insurance premium

Deductions	How much ($)	How often
5a. Type: ☐		
5b. Type: ☐		
5c. Type: ☐		
5d. Type: ☐		

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American Indian/Alaskan Native Income

6. Has any income reported for this person come from any of these sources:

- Per capita payments from a tribe that came from natural resources, usage rights, leases
- Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian Trust Land by the Department of the Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

6a. If YES: How much ($) How often

Estimated Income for Next Year (optional)

7. If this person's income is not steady month to month, what is his or her estimated income next year? $_____

APPENDIX B

STATE of RHODE ISLAND

HealthSource RI and RI Executive Office of Health & Human Services

Notice of Privacy Practices

This notice describes how personal and medical information about individuals may be collected, used and disclosed by HealthSourceRI and how individuals may get access to this information.

HealthSource RI is strongly committed to protecting the privacy of its users. Personally identifiable information will only be used to help users find, apply for, buy, and enroll into health coverage, including both public and private options. We use industry-leading technologies to ensure the security and confidentiality of the personally identifiable information provided to us by our users.

If at any time an individual has questions about their consent to share personally identifiable information or would like to revoke consent for HealthSource RI to use their personally identifiable information for the purposes described in this notice, they must contact HealthSourceRI at 1-855-609-3304.

Throughout this policy, we refer to information that can identify you as a specific individual, such as your name, phone number, email address, Social Security number or credit card number, as "personally identifiable information." "Personally identifiable information" also includes any information involving your health or medical history.

Please note the following important information regarding our privacy policy:

1. **The use and disclosure of information concerning applicants and enrollees will be limited to purposes directly connected with the following:**
    a. The administration of HealthSource RI. Such purposes include determining eligibility for enrollment in health coverage, determining eligibility for other insurance affordability programs or determining eligibility for exemptions from the requirement to have health coverage.
    b. Any investigation, prosecution, or criminal or civil proceeding conducted in connection with the administration of HealthSource RI.
    c. The administration of any other federal or state assisted program which provides assistance, in cash or in kind, or services, directly to individuals on the basis of need.
    d. Any other release will be made with the applicant/enrollee's consent.

2. **The following information describes the collection of personally identifiable information in the normal course of business of HealthSource RI in order to process insurance applications.**
    a. **Registration**
    We begin collecting personally identifiable information from individuals when they register with us. Individuals may register with us through our website (healthsourceri.com) by entering an email address and, if they are creating an account, choosing a password. Individuals may also register with us through our Contact Center by providing certain personal or contact information (e.g., email address, phone number, gender, date of birth) to one of our customer

service representatives.

b. **Applying for Health Insurance and Other Products.**
If an individual applies for a health insurance or other product through our website, we may ask them to provide us with personally identifiable information and/or health information relating to him or her and any family member who will be included on his or her application. This information will be used by the individual's chosen insurance company to process their application. Additionally, we may ask for credit card or bank information, which will be used to process applications or collect any fees associated with applications or insurance premiums upon approval of an application.

c. **Providing a quote or processing applications.**
We may use personally identifiable information to get in touch with applicants/enrollees when necessary to process an application or to provide a quote. For example, emails will be sent throughout the application process to inform applicants/enrollees of the status of the application and to seek additional information that is requested as part of the application.

d. **Customer satisfaction, referrals and other products.**
We or our service providers may contact applicants/enrollees to survey their satisfaction of our service, refer our products and services to other people, and/or to inform them of additional products and services.

3. **We do not sell personally identifiable information to anyone.**

4. **We do not disclose personally identifiable information to third parties, unless one of the following limited exceptions applies.**

I. **Insurance Companies, Licensed Agents/Brokers and Navigators, state and federal government.** When someone submits an application for an insurance product offered by us, then we will disclose his or her personally identifiable information to his or her chosen insurance company to process his or her application.

II. **If someone submits an application for an insurance product offered through an insurance agent or agency, or through a Navigator or other application assister who has a relationship with us, then we may share his or her personally identifiable information with that party for the purposes of processing his or her application or enrollment.** These partners are only allowed to use personally identifiable information to process the requested quote, application or enrollment form and that they are contractually obligated to maintain confidentiality.

III. **Service Providers.** We may disclose personally identifiable information to other companies that help us process or service insurance applications or correspond with applicants/enrollees. For example, we may provide personally identifiable information to a service provider to send enrollees monthly bills and process payments received. The companies we hire to process or service insurance applications or correspond with applicants/enrollees are not allowed to use

personally identifiable information for their own purposes and are contractually obligated to maintain confidentiality.

IV. **Legal Obligations.** We may disclose or report personally identifiable information when we believe, in good faith, that the disclosure is required or permitted under law, for example, to cooperate with regulators or law enforcement authorities or to resolve consumer disputes.

V. **Consent.** We may disclose or report personally identifiable information to third parties only upon written consent from the individual whose personally identifiable information we intend to disclose. For example, we may disclose personally identifiable information to a friend or relative helping an individual to obtain health coverage, but only with that individual's consent to do so.

Outside of the above exceptions, we will not share personally identifiable information with third parties.

5. **We gather anonymous information about users for our internal purposes, and we may share this anonymous information with third parties.**

Anonymous information is any information that does not personally identify an individual, including aggregate demographic information such as the number of visitors to our website from a particular state. We use anonymous information primarily for marketing purposes and to improve the services we offer.

We may use "Cookies," "Clear Gifs," "Internet Protocol" addresses and other monitoring technologies to gather anonymous information. "Cookies" are small files that are stored by your web browser to help a particular system recognize a user and the pages they have visited in a website. "Clear gifs" are tiny graphics with a unique identifier, similar in function to cookies, that are used to track the online movements of website users. More information on each of these tools is below.

"Cookies:" Our website uses cookies to make a user's online experience more convenient. For example, we may use a cookie to store account information between sessions and to maintain information about the quotes a user requested during his or her session. Additionally, we may use data from cookies for a variety of internal purposes, such as studying how users navigate our website. We do not collect any personally identifiable information from cookies. Further, no other information we collect from cookies can be linked back to personally identifiable information.

Most browsers automatically accept cookies, but if you prefer, you can set yours to refuse cookies. Even without a cookie, you can still use most of the features on our website, including obtaining quotes and applying for an insurance policy.

"Clear gifs:" The main difference between a "cookie" and a "clear gif" is that clear gifs are invisible on the page and are much smaller than cookies. We do not collect any personally identifiable information from clear gifs. Further, no information we collect from clear gifs can be linked back to your personally identifiable information.

We use third party web analytics services to track and analyze anonymous usage and volume statistical informaπtion from visitors to help us administer our website, analyze trends, improve our website's performance and to report website traffic. These web analytics services use cook-

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ies, clear gifs, log files and other web monitoring technologies to help track visitor behavior on our behalf. These services do not use these technologies to collect any personally identifiable information from website visitors.

6. **We protect the confidentiality and security of personally identifiable information.**

   We maintain physical, electronic and procedural safeguards to protect your personally identifiable information.

7. **We continue to evaluate our efforts to protect personally identifiable information and make every effort to keep personally identifiable information accurate and up to date.**

   We will conduct a yearly review of any and all privacy risks, including any major updates or changes to our system and/or privacy policy. Any and all risks and changes will be reviewed and addressed as appropriate by our information security and privacy officers. Our information security and privacy officers will also be responsible for the proactive review of the processes by which your personal information is collected and maintained (including when your personally identifiable information is collected or shared with the third parties listed in #4), used, disclosed, retained and disposed of.

   If an individual's personally identifiable information changes or if they wish to dispute the accuracy or integrity of their personally identifiable information or if an individual would like to correct or update their information, they may contact us at 1-855-609-3304.

   Individuals may also update their contact information using the contacts provided above.

   Additionally, names, email addresses and passwords may be updated by clicking on the "Sign in" link on the HealthSource RI website (healthsourceri.com) and signing in using the user's email address and password.

   We will retain your information for as long as your account is active or as needed to provide you services. We will retain and use your information as necessary to comply with our legal obligations, resolve disputes, and enforce our agreements.

   Once an application has been submitted to a health insurance company, individuals may have to contact the insurance company directly to update their application.

8. **We will provide a notice of changes in our information privacy practices.**

   If we are going to use personally identifiable information in a manner different from that stated at the time of collection, we will notify all users via email or if previously requested, by another contact method. Users will have a choice as to whether or not we use their personally identifiable information in this new or different manner. If we make any material changes to our privacy practices that do not affect the personally identifiable information already stored in our database, we will post a prominent notice in the privacy portion of our website notifying users of the change.

   If our system undergoes any major changes we will post a prominent notice in the privacy portion of our website notifying users of the change.

   This notice and any future changes to it will be available on our website.

9. **Individuals may opt out of receiving satisfaction surveys and/or information on additional products and services from us.**

   We may contact users to survey their satisfaction with our service and/or to inform them of additional products and services.

   Users may opt out of these surveys and/or notices by contacting us 1-855-609-3304.

   Users will still receive communications from us regarding insurance quotes, applications or policies even if they opt out of receiving our surveys and/or notices of additional products and services.

10. **We are available to answer any questions that may arise about our privacy policy or our information privacy practices.**

    Questions can be sent to us by calling our Contact Center at 1-855-609-3304. We will respond to such questions within 30 days.

11. **Links to Other Websites**

    Our website contains links to other websites. Please note that when you click on one of these links you are "clicking" to another website. We are not responsible for the information privacy practices or the content of such websites. We encourage you to read the privacy policies of these linked websites as their information privacy practices may differ from ours.

NEED HELP WITH YOUR APPLICATION? Visit healthsourceri.com, dhs.ri.gov or ohhs.ri.gov or call us at 1-855-609-3304. Para obtener una copia de este formulario en Español, llame 1-855-609-3304. If you need help in a language other than English, call 1-855-609-3304 and tell the customer service representative the language you need. We'll get you help at no cost. TTY users should call 1-888-657-3173.

RHODE ISLAND
VOTER REGISTRATION FORM

Please print clearly in ink. All information is required unless marked optional.

YOU MAY USE THIS FORM TO:

- Register to vote in Rhode Island.
- Change your name and/or address on your registration.
- Choose a political party or change parties.

TO REGISTER TO VOTE IN RI YOU MUST BE:

- A legal resident of Rhode Island.
- A citizen of the United States.
- At least 16 years of age.
  (You must be at least 18 years of age to vote on Election Day.)

INSTRUCTIONS

Box 2: REQUIRED. Rhode Island citizens who are at least 16 years of age may pre-register to vote using this form. If you fail to check either of these boxes, this form will be returned to you. If you checked NO to either of these statements, do not complete this form.

Box 3: If you are registering to vote for the first time in Rhode Island by mail or if someone else turns this form in for you, it is **REQUIRED** that you provide your driver's license number or state ID number issued by the RI Department of Motor Vehicles (DMV). If you do not have either, you must provide the last 4 digits of your Social Security Number. If you do not provide the above information or it cannot be verified, you will be required to provide identification to an election official before voting. Acceptable forms of identification are on the Board of Elections website at http://www.elections.ri.gov or contact your local Board of Canvassers (see reverse side of this form).

Box 5: A person may have only one legal residence. You must register from your legal residence. A post office box or rural route may only be used as a "Mailing Address" in Box 6.

Box 9: If you want to affiliate to vote, choose a party. If you leave Box 9 blank, you will be listed as unaffiliated.

Box 10: You must SIGN and DATE the registration form. If you fail to sign and date the form, it will be returned to you.

Box 11: If you are updating your voter registration because you legally changed your name, enter your previous legal name.

Box 12: If you are updating your voter registration because of an address change, enter your previous address, **even if out-of-state.**

You will receive an acknowledgement receipt of this voter registration form within 3 weeks. If you do not receive it, contact your local Board of Canvassers (see reverse side for list). For questions and deadlines relating to this form, visit the Board of Elections website at http://www.elections.ri.gov or contact your local Board of Canvassers (see reverse side for list).

(This form may be reproduced)

1. Check Boxes that Apply: ☐ New Voter Registration ☐ Address Change ☐ Party Change ☐ Name Change

2. I am a U.S. Citizen and resident of Rhode Island. ☐ Yes ☐ No

I am at least 16 years of age. (You must be at least 18 years of age to vote.) ☐ Yes ☐ No

If you checked NO to either of these statements, do not complete this form.

3. RI driver's license or ID Number: _____

If you do not have a RI driver's license or ID, enter last 4 digits of your social security number: _____

If you do not enter either number, see instructions for Box 3.

4. Last Name	Suffix (if any)	First Name	Middle Name (or initial)

5. Home Address (Do not enter a post office box)	Apt.	City/Town	State	ZIP Code
			RI	

6. Mailing Address (If different from Box 5)	Apt.	City/Town	State	ZIP Code

7. Date of Birth (mm/dd/yyyy)
Month Day Year

8. Phone No./ E-mail Address (optional)

9. Party Affiliation: ☐ Democrat ☐ Moderate ☐ Republican ☐ Unaffiliated ☐ Other_____

10. I swear or affirm that:

- I am not incarcerated in a correctional facility upon a felony conviction.
- I am not presently judged "mentally incompetent" to vote by a court of law.
- The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, I may be fined, imprisoned, or (if not a U.S. citizen) deported from or refused entry into the United States.

Official Use For Barcode

PLEASE SIGN FULL NAME OR PLACE MARK BELOW

Signed _____ **Date:** _____ **(mm/dd/yyyy)**

Are you interested in working at the polls? (check box below) ☐

Warning: If you sign this form and know it to be false, you can be convicted and fined up to $5,000 or jailed up to 10 years.

11. PREVIOUS NAME (if different from Box 4)

12. PREVIOUS ADDRESS OF REGISTRATION (City/Town, State, ZIP & County)

02/2012 Regs
Form Revised 12/2012

Return Address

_____

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Postage Required Post Office will not deliver without proper postage.

Mail To: **BOARD OF CANVASSERS**

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**********FOLD HERE & TAPE AT TOP**********

INSTRUCTIONS FOR MAILING THE VOTER REGISTRATION FORM

An applicant who chooses to mail his/her voter registration form shall do so in the following manner:

1. Fold the form at the dotted line and tape the bottom to the top of the form.
2. From the list below, locate the address of the board of canvassers in the city or town in which you are registering to vote and insert that address in the appropriate space beneath "**Mail To: BOARD OF CANVASSERS"** on the addressed side of the voter registration form. Insert your return address in the space provided.

NOTICE: *It is against the law for anyone to interfere with your privacy in registering to vote or in choosing a political party. If you believe someone has interfered with your right to register or not register, or with your privacy in making this decision, or in choosing a political party, you may file a complaint with the State Board of Elections, 50 Branch Avenue, Providence, Rhode Island 02904.*

LOCAL BOARDS OF CANVASSERS

Barrington Town Hall, 283 County Rd., Barrington, RI 02806

Bristol Town Hall, 10 Court St., Bristol, RI 02809

Burrillville Town Hall, 105 Harrisville Main St., Harrisville, RI 02830

Central Falls City Hall, 580 Broad St.., Central Falls, RI 02863

Charlestown Town Hall, 4540 S. County Trail, Charlestown, RI 02813

Coventry Town Hall, 1670 Flat River Rd., Coventry, RI 02816

Cranston City Hall, 869 Park Ave., Cranston, RI 02910

Cumberland Town Hall, 45 Broad St., Cumberland, RI 02864

East Greenwich Town Hall, PO Box 111, East Greenwich, RI 02818

East Providence City Hall, 145 Taunton Ave., East Providence, RI 02914

Exeter Town Hall, 675 Ten Rod Rd., Exeter, RI 02822

Foster Town Hall, 181 Howard Hill Rd., Foster, RI 02825

Glocester Town Hall 1145 Putnam Pike PO Drawer B, Glocester, RI 02814

Hopkinton Town Hall, 1 Town House Rd., Hopkinton, RI 02833

Jamestown Town Hall, 93 Narragansett Ave., Jamestown, RI 02835

Johnston Town Hall, 1385 Hartford Ave., Johnston, RI 02919

Lincoln Town Hall, 100 Old River Rd., PO Box 100, Lincoln, RI 02865

Little Compton Town Hall, PO Box 226, Little Compton, RI 02837

Middletown Town Hall, 350 East Main Rd., Middletown, RI 02842

Narragansett Town Hall, 25 Fifth Ave., Narragansett, RI 02882

New Shoreham Town Hall, PO Drawer, 220 Block Island, RI 02807

Newport City Hall, 43 Broadway, Newport, RI 02840

N. Kingstown Town Hall, 80 Boston Neck Rd., North Kingstown, RI 02852

North Providence Town Hall, 2000 Smith St., North Providence, RI 02911

North Smithfield Municipal Annex, 575 Smithfield Rd., North Smithfield, RI 02896

Pawtucket City Hall, 137 Roosevelt Ave., Pawtucket, RI 02860

Portsmouth Town Hall, 2200 East Main Rd., Portsmouth, RI 02871

Providence City Hall, 25 Dorrance St., Providence, RI 02903

Richmond Town Hall, 5 Richmond Townhouse Rd., Wyoming, RI 02898

Scituate Town Hall, PO Box 328, North Scituate, RI 02857

Smithfield Town Hall, 64 Farnum Pike, Smithfield, RI 02917

S. Kingstown Town Hall, 180 High St., Wakefield, RI 02879

Tiverton Town Hall, 343 Highland Rd., Tiverton, RI 02878

Warren Town Hall, 514 Main St., Warren, RI 02885

Warwick City Hall, 3275 Post Rd., Warwick, RI 02886

W. Greenwich Town Hall 280 Victory Highway, W. Greenwich, RI 02817

West Warwick Town Hall, 1170 Main St., West Warwick, RI 02893

Westerly Town Hall, 45 Broad St., Westerly, RI 02891

Woonsocket City Hall, P.O. Box B, 169 Main St., Woonsocket, RI 02895

Voter Registration Questions May Be Addressed To:

Rhode Island Board of Elections
50 Branch Avenue
Providence, RI 02904
elections@elections.ri.gov