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

APPLICATION FOR

Healthcare Coverage

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

Use this application to see what healthcare coverage you qualify for:	• Free healthcare coverage from Rhode Island Medicaid or RIte Care • Tax credits to help you pay your monthly health insurance bill • Private Health Plans
Apply faster online:	**Apply faster online at www.healthsourceri.com, www.dhs.ri.gov or www.eohhs.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 healthcare 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 • 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 to determine what healthcare coverage you are qualified for. We will keep the information you provide private as required by law.
Send your complete and signed application to:	RI Department of Human Services P.O. Box 8709 Cranston, RI 02920-8787
Get help with this application:	• Online: www.healthsourceri.com, www.dhs.ri.gov or www.eohhs.ri.gov • Phone: Call the Customer Support Center at **1-855-609-3304 or 1-800-745-5555 (TTY)** • In person: To find in-person application assistance visit www.healthsourceri.com, www.dhs.ri.gov or www.eohhs.ri.gov or visit the Walk-In Center at 401 Wampanoag Trail, East Providence, RI 02915 (Monday through Friday 8:00 a.m. - 6:00 p.m. and Saturdays from 8:00 a.m. to 12:00 p.m. during open enrollment only)

NEED HELP WITH YOUR APPLICATION? Visit healthsourceri.com, dhs.ri.gov or eohhs.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 1-800-745-5555.

Definitions

HealthSource RI: HealthSource RI is a unique resource that connects Rhode Islanders to a range of health insurance options. It provides tools, resources, and information you need to stay informed and healthy. Whether you need insurance for yourself, your family, or your employees, you'll find everything you need to weigh your options and choose the right plan. Our website lets you compare your coverage options side-by-side—in simple language. And our experts are available during extended hours to help you with any questions, concerns, or issues.

Whichever plan you choose, you'll get essential health benefits, including doctor visits, hospitalizations, maternity care, ER visits, and prescriptions. You may also qualify for a tax credit to help pay for insurance. HealthSource RI can also provide information about and assistance with applications for public programs such as Rhode Island Medicaid.

Premium: Your monthly premium is the amount that you pay each month for your health insurance. You must pay your monthly premium on time each month in order to keep your health insurance active. On HealthSource RI, you can have your premium taken right out of your bank account every month. You can also pay with a check or a money order.

Deductible: Your deductible is the amount you owe for certain healthcare services before your health insurance begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Advance Premium Tax Credit (APTC): HealthSource RI offers tax credits to help Rhode Islanders pay for their monthly health insurance costs. These tax credits are based on how much you earn — if you're single, you can make up to $46,680, while a family of four people can make up to $95,400. An Advance Premium Tax Credit is paid directly to your insurance provider.

Cost-Sharing Reductions: Cost Sharing Reductions lower the amount of money you spend on your medical care. You will pay less for co-pays, deductibles, and co-insurance when you see the doctor, go to the hospital, or get a prescription. These Cost Sharing Reduction discounts are only available on Silver plans.

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 Medicaid Program: Public health coverage programs for eligible Rhode Island residents, funded through Medicaid and the Children's Health Insurance Program. The Rhode Island Medicaid program delivers health care through its RIte Care managed care plans for families with children, Rhody Health Partners and Connect Care health care options for adults and elders, and an array of institutional and community-based programs that deliver long-term services and supports.

Healthcare 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 Medicaid, 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, immigration status and income, as well as to prevent fraud and verify healthcare 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 a decision that was made by HealthSource RI regarding your eligibility, you have a right to appeal that decision. Pursuant to EOHHS Rule #0110, "Complaints and Hearings," you may file an appeal of an eligibility determination and the matter will be heard by a hearing officer. You must file an appeal within the 30 day period that begins five days after the date your notice was sent via email (transmittal date) or by U.S. Mail (postmark date) by HealthSource RI. Once you have received the notice, you can request an appeal. The notice contains information about how to request an appeal. Please call HealthSource RI at (855)712-9158 with any questions.

If the appeal is for a decision on Rhode Island Medicare 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 sources. In order to review your Application and to determine whether you qualify for help paying for your health care coverage, 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 may be made available to you upon request. You may contact HealthSource RI to request a copy.

HealthSource RI is not responsible for administering your commercial 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 Medicaid only. EOHHS and HealthSource RI must:

Give you 10 days to provide the information we need. The ten days begins five days after the date the request for additional information was sent via email (transmittal date) or U.S. mail (postmark date). If you don't give us the information or ask for more time we may deny, terminate, suspend, or change your health care coverage.

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

Give you a written decision, in most cases, within 30 days. Healthcare coverage requiring a determination of disability or level of care may take up to 90 days.

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

Your responsibilities for Rhode Island Medicaid 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 Medicaid 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 Medicaid coverage.

Things you should know for Rhode Island Medicaid only:

By asking for and receiving Rhode Island Medicaid, 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 Medicaid, you assign your medical support rights to the Office of Child Support Services.

If you stop getting Rhode Island Medicaid, 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 Medicaid 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.

Continuation or Reinstatment of Health Coverage also known as "aid pending" may be available if you appeal a determination affecting your eligibility or the scope of your health coverage and services. You must request aid pending during the 10 day advance notice period that begins on the fifth day after the notice of eligibility or change in health coverage is sent by EOHHS via email or the U.S. Mail.

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 you may obtain coverage as soon as possible, or, if you are provided conditional eligibility, you may avoid a disruption in coverage.

If you enroll in a qualified health plan through HealthSource RI and you have a change in income, you must notify HealthSource RI within thirty (30) days of that change. 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 tax credit 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 may 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 Healthcare Coverage

About You and Your Family

Please include yourself; other family members; anyone who is included on your federal tax return, if you file one; Only include your unmarried partner (your boyfriend or girlfriend) if you live together AND you have a child together. If you do not have a child together, do not include your unmarried partner. Also, do not include your roommate. 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 do not need to provide 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 (Sr., Jr., I, II, III, IV)

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 (Sr., Jr., I, II, III, IV)

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 different on his or her 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 (Sr., Jr., I, II, III, IV)

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 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 (Sr., Jr., I, II, III, IV)

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.

Contact Information and Address– Primary Applicant

1. First Name | Middle Name | Last Name | Suffix (Sr., Jr., I, II, III, IV)

1a. Primary Phone Number ☐ Cell ☐ Home ☐ Work ( )

1b. Secondary Phone Number ☐ Cell ☐ Home ☐ Work ( )

1c. Email Address (required)

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

6a. I currently do not have a permanent home ☐
If you do not have a permanent home you may enter the address of a person you stay with, a homeless shelter, or the nearest DHS office.

Personal Information

7. Ethnicity (Optional) ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ other Hispanic ☐ non-Hispanic

8. Race (Optional) ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian ☐ Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other

9. Are you pregnant? ☐ Yes ☐ No

9a. If YES: Pregnancy Due Date: Month:_____ Day:_____ Year:_____

9b. Number of babies expected:

10. Are you currently incarcerated? ☐ Yes ☐ No

10a. If YES: Expected Release Date: Month:_____ Day:_____ Year:_____

Citizenship and Immigration Information

You don't need to answer questions 11-15 if you're not applying for coverage.

11. Are you a US citizen or national? ☐ Yes ☐ No

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. Please provide information on your immigration documentation

If you have an eligible immigration status, please provide information on your documentation below.

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 Card Number:	
13e. Refugee Travel Document (I-571) Alien #:	☐		
13f. Employment Authorization Card (I-766) Alien #:	☐	I-776 Card Number:	
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: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	
13m. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) Sevis ID: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	
13n. Other documents or status types Document Description:_____ Alien Number:_____ Sevis ID: _____ Country of Issuance: _____	☐	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

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15. Are you an honorably discharged veteran or an active duty member in the U.S. military? ☐ Yes ☐ No

American Indian & Alaskan Native Information

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

16. Are you American Indian or an 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 service from the Indian Health Service, Tribal Health Program or Urban Indian Health Program? ☐ Yes ☐ No

17d. Are you eligible to get services from the Indian Health Service, Tribal Health Program or Urban Indian Health Programs through a referral from one of these programs? ☐ Yes ☐ No

Your Disability and Disability Services Information

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

Additional Questions about You

19. Were you in the Rhode Island foster care system on your 18th birthday? You may be eligible for low-cost insurance or Medicaid. Call the Contact Center for details.	☐ 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 Income

21. Do you receive employment income (wages/salaries/tips)? **If NO**, skip to question 22.	☐ Yes ☐ No
21a. Do you currently work as an employee for a business or an organization? **If NO**, skip to question 22.	☐ Yes ☐ No

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

21b. Employer 1 Name:	**21c.** Or Employer Identification Number:
21d. Employer Address: City State Zip Code	
21e. Wages/Tips before Taxes:	**21f.** Wages/Tips Frequency: ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

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

21g. Employer 1 Name:	**21h.** Employer Identification Number
21i. Employer Address City State Zip Code	
21j. Wages/Tips before Taxes:	**21k.** Wages/Tips Frequency: ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
22. Do you receive self-employment income? **If YES**, type of work_____ ☐ Profit ☐ Loss	**22b.** Self-Employment Net Income: _____ This is the net income you earn from your own trade of business. For example, any net income (profit) you earn from goods you sell or services you provide to others counts as self-employment income. Self-employment income could also come from a distributive share from a partnership.

Photocopy this sheet to add additional employers for the primary applicant

Your Other Income

Note: Do not count the following as income: child support, gifts, Supplemental Security Income (SSI), Veterans' disability payments, workers compensation, Rhode Island Works cash assistance, Supplemental Nutrition Assistance Program (SNAP) benefits, proceeds from loans (such as student loans, home equity loans, or bank loans), or scholarships for classes (do list the portion of scholarships, awards or fellowship grants used for living expenses as income).

23. Rental or Royalty Income? *Rental income is the amount someone pays you to use your property minus the amount you have spent on maintaining your property. Royalty income includes any payments you get from a patent, copyright, or some other natural resource you own. Be sure not to include any rental or royalty income that you have already included in your Self Employment Income.* ☐ Yes ☐ No

If YES, amount of Rent or Royalty Income: _____

23a. Status: ☐ Profit ☐ Loss **23c.** Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

24. Capital Gains/Investment Income (or losses) ☐ Yes ☐ No

If YES, provide more information about your dividend payments, interest payments, capital gains or losses, income from partnership corporations or trusts that was not included in your self-employment income.

24a. Interest (including tax-exempt interest): _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

24b. Net Capital Gains (profit after subtracting capital losses): _____

Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly Status: ☐ Profit ☐ Loss

24c. Dividends: _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

24d. Income from Partnerships Corporations and Trusts: _____

Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

25. Farming/Fishing Income _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

Status: ☐ Profit ☐ Loss

26. Unemployment _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

27. Social Security Disability Income (SSDI) *Do not include Supplemental Security Income (SSI) Income or any Veterans' disability benefits.*

_____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

28. Retirement Income (such as 401K, Social Security Retirement Income, taxable IRA distributions, pensions, military retirement or annuities)

_____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

29. Alimony/Spousal Support _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

30. Other Income *(such as canceled debts, court awards, jury duty pay not given to an employer, cash support, gambling, prizes, or foreign earned income. Please include taxable refunds, credits or offsets of local or state income taxes below).*

_____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

Your Tax Deductions

Deduction: The purpose of a tax deduction is to reduce your taxable income. For HealthSource RI's purposes, if you pay for any of these expenses, that means your income is lower and you might be able to receive a larger tax credit to help lower your insurance costs. Some items that you pay for can be deducted on your income tax return. If you choose to tell us about these deductions, it may lower the cost of your health insurance.

31. Fill out the information below for any expenses that may be claimed as deductions (if filing taxes). Allowable deductions include:

Alimony Paid	Health Savings Account (HSA) Contributions	Self-employment Tax Deductions
Interest Paid on Student Loans	IRA/401K Deductions	Self-employment Retirement Plans and Self-employment Health Insurance
Educator Expenses	Penalties paid for early withdrawal from savings	Business Expenses of performing artists, reservists, and fee-basis government officials
Tuition and School Fees	Moving Costs related to a job change	Domestic Product Activities

Deductions	How much ($)	Frequency
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

Your Estimated Annual Income for Next Year (optional)

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

Family Member 2 - Skip to page 27 if there is no one else in your family

1. First Name | M.I. | Last Name | Suffix (SR., Jr., I, II, III, IV)

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. 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
- ☐ Husband/Wife
- ☐ 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

5. 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

6. Ethnicity (Optional) ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ other Hispanic ☐ non-Hispanic

7. Race (Optional) ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian ☐ Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other

8. Is this person pregnant? ☐ Yes ☐ No

9. If YES: Pregnancy Due Date: Month:_____ Day:_____ Year:_____
9a. Number of babies expected:

10. Is this person currently incarcerated? ☐ Yes ☐ No
10a. If YES: Expected Release Date: Month:_____ Day:_____ Year:_____

Family Member 2 - Citizenship and Immigration Information

You don't need to answer questions 11-15 if this person is not applying for coverage.

11. Is this person a US citizen or national? ☐ Yes ☐ No

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. Please provide information on this person's immigration documentation

If this person has an eligible immigration status, please provide information on his/her documentation below.

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 Card Number:	
13e. Refugee Travel Document (I-571) Alien #:	☐		
13f. Employment Authorization Card (I-766) Alien #:	☐	I-776 Card Number:	
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: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	
13m. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) Sevis ID: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	
13n. Other documents or status types Document Description:_____ Alien Number:_____ Sevis ID: _____ Country of Issuance: _____	☐	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

15. Is this person an honorably discharged 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 Medicaid protections and for special benefits through HealthSource RI.

16. Is this person American Indian or an 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 service from the Indian Health Service, Tribal Health Program or Urban Indian Health Program? ☐ Yes ☐ No

17d. Is this person eligible to get services from the Indian Health Service, Tribal Health Program or Urban Indian Health Programs through a referral from one of these programs? ☐ Yes ☐ No

Family Member 2 - Disability and Disability Services Information

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

Family Member 2 - Additional Questions

19. If over 18 years of age, was this person in the Rhode Island Foster Care system on his or her 18th birthday? *You may be eligible for low-cost insurance or Medicaid. Call the Contact Center for details.*	☐ Yes ☐ No
20. 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
Parent Outside the Home 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, I know I'll be asked to cooperate with the Office of Child Support Services that collects medical support from a non-custodial parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and I may not have to cooperate.
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:		

Photocopy this sheet to add additional employers for the primary applicant

Family Member 2 - Income

22. Does this person receive employment income (wages/salaries/tips)? ☐ Yes ☐ No
If NO, skip to question 23.

22a. Does this person currently work as an employee for a business or an organization? ☐ Yes ☐ No
If NO, skip to question 23.

If this person is currently employed, please complete the following information about his/her employer and income.

22b. Employer 1 Name: | **22c.** Or Employer Identification Number:

22e. Employer Address: City State Zip Code

22f. Wages/Tips before Taxes: | **22g.** Wages/Tips Frequency:
☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

If this person has another employer, please complete the following information on that employer and income.

22h. Employer 1 Name: | **22i.** Employer Identification Number

22j. Employer Address City State Zip Code

22k. Wages/Tips before Taxes: | **22l.** Wages/Tips Frequency:
☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

23. Does this person receive self-employment income?

Status: ☐ Profit ☐ Loss

23b. Self-Employment Net Income: _____
This is the net income you earn from your own trade or business. For example, any net income (profit) you earn from goods you sell or services you provide to others counts as self-employment income. Self-employment income could also come from a distributive share from a partnership.

Family Member 2 - Other Income

Note: Do not count the following as income: child support, gifts, Supplemental Security Income (SSI), Veterans' disability payments, workers compensation, Rhode Island Works cash assistance, Supplemental Nutrition Assistance Program (SNAP) benefits, proceeds from loans (such as student loans, home equity loans, or bank loans), or scholarships for classes (do list the portion of scholarships, awards or fellowship grants used for living expenses as income).

24. Rental or Royalty Income? *Rental income is the amount someone pays you to use your property minus the amount you have spent on maintaining your property. Royalty income includes any payments you get from a patent, copyright, or some other natural resource you own. Be sure not to include any rental or royalty income that you have already included in your Self Employment Income.* ☐ Yes ☐ No
If YES, amount of Rent or Royalty Income: _____
24a. Status: ☐ Profit ☐ Loss **24c.** Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

25. Capital Gains/Investment Income (or losses) ☐ Yes ☐ No
If YES, provide more information about this person's dividend payments, interest payments, capital gains or losses, income from partnership corporations or trusts that was not included in this person's self-employment income.
25a. Interest (including tax-exempt interest): _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
25b. Net Capital Gains (profit after subtracting capital losses): _____
Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly Status: ☐ Profit ☐ Loss
25c. Dividends: _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
25d. Income from Partnerships Corporations and Trusts: _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

26. Farming/Fishing Income _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Status: ☐ Profit ☐ Loss

27. Unemployment _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

28. Social Security Disability Income (SSDI) *Do not include Supplemental Security Income (SSI) Income or any Veterans' disability benefits).*
_____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

28. Retirement Income (such as 401K, Social Security Retirement Income, taxable IRA distributions, pensions, military retirement or annuities)
_____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

30. Alimony/Spousal Support _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

31. Other Income *(such as canceled debts, court awards, jury duty pay not given to an employer, cash support, gambling, prizes, or foreign earned income. Please include taxable refunds, credits or offsets of local or state income taxes below).*
_____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

Family Member 2 - Tax Deductions

Deduction: The purpose of a tax deduction is to reduce your taxable income. For HealthSource RI's purposes, if you pay for any of these expenses, that means your income is lower and you might be able to receive a larger tax credit to help lower your insurance costs. Some items that you pay for can be deducted on your income tax return. If you choose to tell us about these deductions, it may lower the cost of your health insurance.

32. Fill out the information below for any expenses that may be claimed as deductions (if filing taxes). Allowable deductions include:

Alimony Paid	Health Savings Account (HSA) Contributions	Self-employment Tax Deductions
Interest Paid on Student Loans	IRA/401K Deductions	Self-employment Retirement Plans and Self-employment Health Insurance
Educator Expenses	Penalties paid for early withdrawal from savings	Business Expenses of performing artists, reservists, and fee-basis government officials
Tuition and School Fees	Moving Costs related to a job change	Domestic Product Activities

Deductions	How much ($)	Frequency
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

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

33. If this person's income is not fixed month to month, how much do you think this person will make next year? $_____

Family Member 3 - Skip to page 27 if there is no one else in your family

1. First Name | M.I. | Last Name | Suffix (SR., Jr., I, II, III, IV)

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. 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
- ☐ Husband/Wife
- ☐ 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

5. 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

6. Ethnicity (Optional) ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ other Hispanic ☐ non-Hispanic

7. Race (Optional) ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian ☐ Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other

8. Is this person pregnant? ☐ Yes ☐ No

9. If YES: Pregnancy Due Date: Month:_____ Day:_____ Year:_____

9a. Number of babies expected:

10. Is this person currently incarcerated? ☐ Yes ☐ No

10a. If YES: Expected Release Date: Month:_____ Day:_____ Year:_____

Family Member 3 - Citizenship and Immigration Information

You don't need to answer questions 11-15 if this person is not applying for coverage.

11. Is this person a US citizen or national? ☐ Yes ☐ No

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. Please provide information on this person's immigration documentation

If this person has an eligible immigration status, please provide information on his/her documentation below.

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 Card Number:	
13e. Refugee Travel Document (I-571) Alien #:	☐		
13f. Employment Authorization Card (I-766) Alien #:	☐	I-776 Card Number:	
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: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	
13m. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) Sevis ID: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	
13n. Other documents or status types Document Description:_____ Alien Number:_____ Sevis ID: _____ Country of Issuance: _____	☐	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

15. Is this person an honorably discharged 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 Medicaid protections and for special benefits through HealthSource RI.

16. Is this person American Indian or an 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 service from the Indian Health Service, Tribal Health Program or Urban Indian Health Program? ☐ Yes ☐ No

17d. Is this person eligible to get services from the Indian Health Service, Tribal Health Program or Urban Indian Health Programs through a referral from one of these programs? ☐ Yes ☐ No

Family Member 3 - Disability and Disability Services Information

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

Family Member 3 - Additional Questions

19. If over 18 years of age, was this person in the Rhode Island Foster Care system on his or her 18th birthday? *You may be eligible for low-cost insurance or Medicaid. Call the Contact Center for details.*	☐ Yes ☐ No
20. 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
Parent Outside the Home 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, I know I'll be asked to cooperate with the Office of Child Support Services that collects medical support from a non-custodial parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and I may not have to cooperate.
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:		

Photocopy this sheet to add additional employers for the primary applicant

Family Member 3 - Income

22. Does this person receive employment income (wages/salaries/tips)? **If NO**, skip to question 23.	☐ Yes ☐ No
22a. Does this person currently work as an employee for a business or an organization? **If NO**, skip to question 23.	☐ Yes ☐ No

If this person is currently employed, please complete the following information about his/her employer and income.

22b. Employer 1 Name:		**22c.** Or Employer Identification Number:	
22e. Employer Address:	City	State	Zip Code
22f. Wages/Tips before Taxes:		**22g.** Wages/Tips Frequency: ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly	

If this person has another employer, please complete the following information on that employer and income.

22h. Employer 1 Name:		**22i.** Employer Identification Number	
22j. Employer Address	City	State	Zip Code
22k. Wages/Tips before Taxes:		**22l.** Wages/Tips Frequency: ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly	
23. Does this person receive self-employment income? Status: ☐ Profit ☐ Loss		**23b.** Self-Employment Net Income: _____ *This is the net income you earn from your own trade or business. For example, any net income (profit) you earn from goods you sell or services you provide to others counts as self-employment income. Self-employment income could also come from a distributive share from a partnership.*	

Family Member 3 - Other Income

Note: Do not count the following as income: child support, gifts, Supplemental Security Income (SSI), Veterans' disability payments, workers compensation, Rhode Island Works cash assistance, Supplemental Nutrition Assistance Program (SNAP) benefits, proceeds from loans (such as student loans, home equity loans, or bank loans), or scholarships for classes (do list the portion of scholarships, awards or fellowship grants used for living expenses as income).

24. Rental or Royalty Income? *Rental income is the amount someone pays you to use your property minus the amount you have spent on maintaining your property. Royalty income includes any payments you get from a patent, copyright, or some other natural resource you own. Be sure not to include any rental or royalty income that you have already included in your Self Employment Income.* ☐ Yes ☐ No
If YES, amount of Rent or Royalty Income: _____
24a. Status: ☐ Profit ☐ Loss **24c.** Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

25. Capital Gains/Investment Income (or losses) ☐ Yes ☐ No
If YES, provide more information about this person's dividend payments, interest payments, capital gains or losses, income from partnership corporations or trusts that was not included in this person's self-employment income.
25a. Interest (including tax-exempt interest): _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
25b. Net Capital Gains (profit after subtracting capital losses): _____
Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly Status: ☐ Profit ☐ Loss
25c. Dividends: _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
25d. Income from Partnerships Corporations and Trusts: _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

26. Farming/Fishing Income _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Status: ☐ Profit ☐ Loss

27. Unemployment _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

28. Social Security Disability Income (SSDI) *Do not include Supplemental Security Income (SSI) Income or any Veterans' disability benefits).*
_____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

28. Retirement Income (such as 401K, Social Security Retirement Income, taxable IRA distributions, pensions, military retirement or annuities)
_____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

30. Alimony/Spousal Support _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

31. Other Income *(such as canceled debts, court awards, jury duty pay not given to an employer, cash support, gambling, prizes, or foreign earned income. Please include taxable refunds, credits or offsets of local or state income taxes below).*
_____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

Family Member 3 - Tax Deductions

Deduction: The purpose of a tax deduction is to reduce your taxable income. For HealthSource RI's purposes, if you pay for any of these expenses, that means your income is lower and you might be able to receive a larger tax credit to help lower your insurance costs. Some items that you pay for can be deducted on your income tax return. If you choose to tell us about these deductions, it may lower the cost of your health insurance.

32. Fill out the information below for any expenses that may be claimed as deductions (if filing taxes). Allowable deductions include:

Alimony Paid	Health Savings Account (HSA) Contributions	Self-employment Tax Deductions
Interest Paid on Student Loans	IRA/401K Deductions	Self-employment Retirement Plans and Self-employment Health Insurance
Educator Expenses	Penalties paid for early withdrawal from savings	Business Expenses of performing artists, reservists, and fee-basis government officials
Tuition and School Fees	Moving Costs related to a job change	Domestic Product Activities

Deductions	How much ($)	Frequency
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

Family Member 3 - Estimated Annual Income for Next Year (optional)

33. If this person's income is not fixed month to month, how much do you think this person will make next year? $_____

Family Member 4 - Skip to page 27 if there is no one else in your family

1. First Name | M.I. | Last Name | Suffix (SR., Jr., I, II, III, IV)

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. 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
- ☐ Husband/Wife
- ☐ 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

5. 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

6. Ethnicity (Optional) ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ other Hispanic ☐ non-Hispanic

7. Race (Optional) ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian ☐ Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other

8. Is this person pregnant? ☐ Yes ☐ No

9. If YES: Pregnancy Due Date: Month:_____ Day:_____ Year:_____

9a. Number of babies expected:

10. Is this person currently incarcerated? ☐ Yes ☐ No

10a. If YES: Expected Release Date: Month:_____ Day:_____ Year:_____

Family Member 4 - Citizenship and Immigration Information

You don't need to answer questions 11-15 if this person is not applying for coverage.

11. Is this person a US citizen or national? ☐ Yes ☐ No

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. Please provide information on this person's immigration documentation

If this person has an eligible immigration status, please provide information on his/her documentation below.

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 Card Number:	
13e. Refugee Travel Document (I-571) Alien #:	☐		
13f. Employment Authorization Card (I-766) Alien #:	☐	I-776 Card Number:	
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: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	
13m. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) Sevis ID: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	
13n. Other documents or status types Document Description:_____ Alien Number:_____ Sevis ID: _____ Country of Issuance: _____	☐	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

15. Is this person an honorably discharged 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 Medicaid protections and for special benefits through HealthSource RI.

16. Is this person American Indian or an 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 service from the Indian Health Service, Tribal Health Program or Urban Indian Health Program? ☐ Yes ☐ No

17d. Is this person eligible to get services from the Indian Health Service, Tribal Health Program or Urban Indian Health Programs through a referral from one of these programs? ☐ Yes ☐ No

Family Member 4 - Disability and Disability Services Information

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

Family Member 4 - Additional Questions

19. If over 18 years of age, was this person in the Rhode Island Foster Care system on his or her 18th birthday? *You may be eligible for low-cost insurance or Medicaid. Call the Contact Center for details.*	☐ Yes ☐ No
20. 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
Parent Outside the Home 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, I know I'll be asked to cooperate with the Office of Child Support Services that collects medical support from a non-custodial parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and I may not have to cooperate.
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:		

Photocopy this sheet to add additional employers for the primary applicant

Family Member 4 - Income

22. Does this person receive employment income (wages/salaries/tips)? ☐ Yes ☐ No
If NO, skip to question 23.

22a. Does this person currently work as an employee for a business or an organization? ☐ Yes ☐ No
If NO, skip to question 23.

If this person is currently employed, please complete the following information about his/her employer and income.

22b. Employer 1 Name: | **22c.** Or Employer Identification Number:

22e. Employer Address: City State Zip Code

22f. Wages/Tips before Taxes: | **22g.** Wages/Tips Frequency: ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

If this person has another employer, please complete the following information on that employer and income.

22h. Employer 1 Name: | **22i.** Employer Identification Number

22j. Employer Address City State Zip Code

22k. Wages/Tips before Taxes: | **22l.** Wages/Tips Frequency: ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

23. Does this person receive self-employment income?

Status: ☐ Profit ☐ Loss

23b. Self-Employment Net Income: _____
This is the net income you earn from your own trade or business. For example, any net income (profit) you earn from goods you sell or services you provide to others counts as self-employment income. Self-employment income could also come from a distributive share from a partnership.

Family Member 4 - Other Income

Note: Do not count the following as income: child support, gifts, Supplemental Security Income (SSI), Veterans' disability payments, workers compensation, Rhode Island Works cash assistance, Supplemental Nutrition Assistance Program (SNAP) benefits, proceeds from loans (such as student loans, home equity loans, or bank loans), or scholarships for classes (do list the portion of scholarships, awards or fellowship grants used for living expenses as income).

24. Rental or Royalty Income? *Rental income is the amount someone pays you to use your property minus the amount you have spent on maintaining your property. Royalty income includes any payments you get from a patent, copyright, or some other natural resource you own. Be sure not to include any rental or royalty income that you have already included in your Self Employment Income.* ☐ Yes ☐ No
If YES, amount of Rent or Royalty Income: _____
24a. Status: ☐ Profit ☐ Loss **24c.** Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

25. Capital Gains/Investment Income (or losses) ☐ Yes ☐ No
If YES, provide more information about this person's dividend payments, interest payments, capital gains or losses, income from partnership corporations or trusts that was not included in this person's self-employment income.
25a. Interest (including tax-exempt interest): _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
25b. Net Capital Gains (profit after subtracting capital losses): _____
Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly Status: ☐ Profit ☐ Loss
25c. Dividends: _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
25d. Income from Partnerships Corporations and Trusts: _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

26. Farming/Fishing Income _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Status: ☐ Profit ☐ Loss

27. Unemployment _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

28. Social Security Disability Income (SSDI) *Do not include Supplemental Security Income (SSI) Income or any Veterans' disability benefits).*
_____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

28. Retirement Income (such as 401K, Social Security Retirement Income, taxable IRA distributions, pensions, military retirement or annuities)
_____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

30. Alimony/Spousal Support _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

31. Other Income *(such as canceled debts, court awards, jury duty pay not given to an employer, cash support, gambling, prizes, or foreign earned income. Please include taxable refunds, credits or offsets of local or state income taxes below).*
_____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

Family Member 4 - Tax Deductions

Deduction: The purpose of a tax deduction is to reduce your taxable income. For HealthSource RI's purposes, if you pay for any of these expenses, that means your income is lower and you might be able to receive a larger tax credit to help lower your insurance costs. Some items that you pay for can be deducted on your income tax return. If you choose to tell us about these deductions, it may lower the cost of your health insurance.

32. Fill out the information below for any expenses that may be claimed as deductions (if filing taxes). Allowable deductions include:

Alimony Paid	Health Savings Account (HSA) Contributions	Self-employment Tax Deductions
Interest Paid on Student Loans	IRA/401K Deductions	Self-employment Retirement Plans and Self-employment Health Insurance
Educator Expenses	Penalties paid for early withdrawal from savings	Business Expenses of performing artists, reservists, and fee-basis government officials
Tuition and School Fees	Moving Costs related to a job change	Domestic Product Activities

Deductions	How much ($)	Frequency
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

Family Member 4 - Estimated Annual Income for Next Year (optional)

33. If this person's income is not fixed month to month, how much do you think this person will make next year? $_____

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

1. Does anyone in the household 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 28.

2. Please indicate who will be filing taxes next year_____

3. Expected Tax Filing Status for Next Year ☐ Single filing taxes ☐ Married filing taxes separately ☐ Married filing jointly

3a. Name of Tax Filer	**3b**. If Filing Jointly – Please indicate the other joint tax payer *if you are married, you have to file jointly to qualify for a tax credit.*

4. Will any of the Tax Filers listed on the application claim any dependents on their tax return? ☐ Yes ☐ No

If YES, Identify 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.

4a. Name of Tax Filer	**4b.** Name of Dependents

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

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

If YES, Please identify all of the dependents that will be on someone else's return.

5a. Name of Dependent	**5b.** Name of Tax Filer

5c. Relationship of Dependent to Tax Filer:

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

Health Coverage Through an Employer – Fill this out for all family members applying for coverage

1. Do you or anyone you are applying for have access to adequate insurance coverage through an employer, (might be a spouse)?
☐ Yes ☐ No

1a. Is the coverage affordable and qualified under the Affordable Care Act? (Ask your employer) ☐ Yes ☐ No

If YES, please provide the information in the table below. **If NO**, go to page 29.

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

2c. Employer Address	City	State	Zip Code

3. Who can we contact at your job about health insurance coverage? Contact Name:	**3a.** Contact Email Address	**3b.** Contact Phone number

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

4a. Enrollment Status		**4b. Upcoming Changes to Your Plan**
☐ Enrolled Now ☐ Plans to Enroll ☐ Not Enrolled	Start Date (MM/DD/YYYY) _____	☐ Employer plans to drop plan 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 ☐ Plans to Enroll ☐ Not Enrolled	Start Date (MM/DD/YYYY) _____	☐ Employer plans to drop plan 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 ☐ Plans to Enroll ☐ Not Enrolled	Start Date (MM/DD/YYYY) _____	☐ Employer plans to drop plan 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 ☐ Plans to Enroll ☐ Not Enrolled	Start Date (MM/DD/YYYY) _____	☐ Employer plans to drop plan 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

9a. What is the annual employee premium (your share of what your health insurance costs) for the least expensive single plan that your employer offers? *A single plan means that you only count what it costs for the employee only. You don't count what it costs to cover a whole family for coverage. We ask for the lowest cost plan to see if you are able to receive a tax credit to help reduce the cost of your insurance - even if you are not enrolled in this specific plan.*

Employee Premium: $_____ Name of Plan_____

9b. What is your/this person's actual premium cost?

Employee Premium: $_____ Frequency of Premium (weekly, every 2 weeks, monthly, yearly) _____

10. Are you currently covered by ANY type of health insurance? ☐ Yes ☐ No

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

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

11. Does anyone on this application have access to 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 _____

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

12. Is anyone on this application enrolled or eligible for other health insurance? ☐ 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 Health Insurance ☐ Peace Corps ☐ Medicare ☐ Tricare ☐ Private/Other

12b. Who is enrolled or eligible for this coverage? Name _____

Name of Plan	Policy Number	Group Number

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

Name _____ Name _____

Name _____ Name _____

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

13. When were you last covered by ANY type of health insurance? ☐ Within the last year (MM/DD/YYYY) ____/____/_____

☐ 1-3 years ago ☐ More than 3 years ago ☐ Never had health insurance ☐ Other/Uninsured

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

14. Does anyone on this application have access to dental insurance? ☐ Yes ☐ No

14a. If YES, Please identify all of the family members who have access to dental insurance. **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 _____

14b. Name of Dental Insurance Company	**14c.** Policy Number	**14d.** Group Number

14e. Type of coverage ☐ Individual ☐ Family

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

Authorized Representative Information

Selecting an Authorized Representative is optional. You may consider selecting an Authorized Representative if you need or would like help with things like making sure that you are aware of important notices or bills for health insurance sent by HealthSource RI. An Authorized Representative should be someone you trust. This person will receive information from HealthSource RI on your behalf, including your HealthSource RI notices with important information and the bills for your insurance coverage. He or she will also have access to your HealthSource RI account. If you want to do so, check "Yes" below and enter your representative's details below. Your authorized representative must be 18 or older and can be a friend, relative, or anyone else you choose to help you.

1. Do you want to appoint 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. Sr. Jr., I, II, III, IV, V etc.)

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

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

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? ☐ Morning ☐ Afternoon ☐ Evening ☐ Weekend ☐ Anytime

1g. Preferred spoken language (**lengua hablada preferida**)	**1h.** Preferred written language **(lenguaje escrito preferido)**
☐ English ☐ Español ☐ Português	☐ English ☐ Español ☐ Português
1i. Company/Organization Name (If Applicable)	**1j.** Organization ID (If Applicable)

1k. 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 TO SHARE DATA FOR ELIGIBILITY DECISIONS

We can help you better if we are able to work with other agencies and professionals that know you and your family. By checking the I Agree box you are giving permission for us to obtain, use and share confidential information about you from a variety of sources including the R.I. Department of Labor and Training, the R.I. Department of Human Services, the R.I. Executive Office of Health and Human Services, the R.I. Department of Health, the R.I. Department of Corrections, and Experian on behalf of Centers for Medicaid and Medicare Services and Social Security Administration.

We will not refuse you any benefits or access to any programs that you are eligible simply because you do not give us permission to obtain, use and share confidential information, however, we are unable to assist you in accessing certain programs and supports that you may be eligible for if we do not have your consent to obtain and share information. Your consent is required in order to determine your eligibility.

You can proceed to shop for and purchase health insurance coverage without completing this consent by contacting our Contact Center at 1-855-840-HSRI (4774), but if you would like to know whether you are eligible for any financial support for the purchase of coverage, whether you are eligible for publicly funded coverage, or other programs and supports, it will be necessary for you to complete this consent.

All information sharing and use that you are authorizing by checking the I Agree box will be done in compliance with all relevant federal and state laws and regulations protecting your privacy, including but not limited to: The Health Insurance Portability and Accounting Act of 1996 (Pub. L. 104-191 known as HIPAA); The R.I. Confidentiality of Health Care Communications and Information (R.I.G.L. 5-37.3-1 et seq.); R.I.G.L. 28-32-5, 28-36-12, 28-42-38, 28-39-19, 28-39-22, 40.1-5-26, 23-3-23, 42-12-22, 40-6-12 and all other applicable laws and regulations. Information will be shared by computer data transfer.

By checking on the I Agree box I consent to the obtaining and use of confidential information about me to determine my eligibility for enrollment in publicly funded health insurance coverage or other publicly funded programs administered through this site, plan, provide, and coordinate benefits and payments.

☐ I Agree to give my Consent to Share Data for Eligibility Decisions

☐ I do not agree to this Consent and understand that my eligibility for certain programs and supports will be impacted by this decision

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

Read Carefully Before Signing

CONSENT FOR USE OF INCOME DATA

In order to determine your eligibility for help paying for your health coverage, we will use income data, including information from tax returns. You will receive a notice with your eligibility determination and may make chances to update the income information used at any time by contacting HealthSource RI.

☐ I Agree to give my Consent for Use of Income Data

☐ I do not give my Consent **and I understand that this will impact my eligibility for helping to pay for health coverage.**

You can choose to have this consent renewed automatically for one, two, three, four or five years. Selecting a longer period of time may make it easier for us to determine your eligibility in future years. Please renew my eligibility automatically for the next:

☐ 5 years (this is the maximum automatic renewal period) ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

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. By signing this document, I certify under penalty of perjury that my answers are correct, including information about citizenship and alien status, and complete to the best of my knowledge. I also acknowledge the following:

- I understand the questions and statements on this application. If I do not understand, I know that I can get help and get answers to my questions by calling HealthSource RI at 1-855-840-4774.
- I understand the penalties for providing false information or breaking the rules.
- I understand that the agency may contact other persons or organizations.
- 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 he or she 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**

HealthSourceRI

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF HUMAN SERVICES

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.)

Family Member - Income			
1. Does this person receive employment income (wages/salaries/tips)? **If NO**, skip to question 4.	☐ Yes ☐ No		
1a. Does this person currently work as an employee for a business or an organization? **If NO**, skip to question 4.	☐ Yes ☐ No		
If this person is currently employed, please complete the following information about his/her employer and income.			
2. Employer 1 Name:	**2a.** Or Employer Identification Number:		
2b. Employer Address: City		State	Zip Code
2c. Wages/Tips before Taxes:	**2d.** Wages/Tips Frequency: ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly		
If this person has another employer, please complete the following information on that employer and income.			
3. Employer 1 Name:	**3a.** Employer Identification Number		
3b. Employer Address City		State	Zip Code
3c. Wages/Tips before Taxes:	**3d.** Wages/Tips Frequency: ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly		
4. Does this person receive self-employment income? Status: ☐ Profit ☐ Loss	**4a.** Self-Employment Net Income: _____ *This is the net income you earn from your own trade or business. For example, any net income (profit) you earn from goods you sell or services you provide to others counts as self-employment income. Self-employment income could also come from a distributive share from a partnership.*		

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

Family Member - Other Income

Note: Do not count the following as income: child support, gifts, Supplemental Security Income (SSI), Veterans' disability payments, workers compensation, Rhode Island Works cash assistance, Supplemental Nutrition Assistance Program (SNAP) benefits, proceeds from loans (such as student loans, home equity loans, or bank loans), or scholarships for classes (do list the portion of scholarships, awards or fellowship grants used for living expenses as income).

1. Rental or Royalty Income? *Rental income is the amount someone pays you to use your property minus the amount you have spent on maintaining your property. Royalty income includes any payments you get from a patent, copyright, or some other natural resource you own. Be sure not to include any rental or royalty income that you have already included in your Self Employment Income.* ☐ Yes ☐ No

If YES, amount of Rent or Royalty Income: _____

1a. Status: ☐ Profit ☐ Loss **1b.** Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

2. Capital Gains/Investment Income (or losses) ☐ Yes ☐ No

If YES, provide more information about this person's dividend payments, interest payments, capital gains or losses, income from partnership corporations or trusts that was not included in this person's self-employment income.

2a. Interest (including tax-exempt interest): _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

2b. Net Capital Gains (profit after subtracting capital losses): _____

Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly Status: ☐ Profit ☐ Loss

2c. Dividends: _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

2d. Income from Partnerships Corporations and Trusts: _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

3. Farming/Fishing Income _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Status: ☐ Profit ☐ Loss

4. Unemployment _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

5. Social Security Disability Income (SSDI) *Do not include Supplemental Security Income (SSI) Income or any Veterans' disability benefits).*
_____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

6. Retirement Income (such as 401K, Social Security Retirement Income, taxable IRA distributions, pensions, military retirement or annuities)
_____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

7. Alimony/Spousal Support _____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

8. Other Income *(such as canceled debts, court awards, jury duty pay not given to an employer, cash support, gambling, prizes, or foreign earned income. Please include taxable refunds, credits or offsets of local or state income taxes below).*
_____ Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

Family Member - Tax Deductions

Deduction: The purpose of a tax deduction is to reduce your taxable income. For HealthSource RI's purposes, if you pay for any of these expenses, that means your income is lower and you might be able to receive a larger tax credit to help lower your insurance costs. Some items that you pay for can be deducted on your income tax return. If you choose to tell us about these deductions, it may lower the cost of your health insurance.

9. Fill out the information below for any expenses that may be claimed as deductions (if filing taxes). Allowable deductions include:

Alimony Paid	Health Savings Account (HSA) Contributions	Self-employment Tax Deductions
Interest Paid on Student Loans	IRA/401K Deductions	Self-employment Retirement Plans and Self-employment Health Insurance
Educator Expenses	Penalties paid for early withdrawal from savings	Business Expenses of performing artists, reservists, and fee-basis government officials
Tuition and School Fees	Moving Costs related to a job change	Domestic Product Activities

Deductions	How much ($)	Frequency
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly
Type:		☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

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

10. If this person's income is not fixed month to month, how much do you think this person will make next year? $_____

Notice to Applicant
Registering to Vote in Rhode Island

The State Board of elections urges all of its citizens to register to vote. Your vote will benefit you and your family.

Included in this packet of forms is a voter registration form. If you would to register to vote, complete and sign the form and mail it to your local Board of Canvassers. (directory listed on the back of the form)

Register to vote

- If you are not registered to vote where you live today, complete the enclosed form.

- Applying to register or declining to register to vote will not affect the amount of assistance provided by this agency.

- If you would like help in completing the voter registration application form, you can bring it with you when you return the other completed forms in this package, or go to the local Board of Canvassers in the city/town where you live. (City/Town directory is on the back of the voter registration form.) The decision whether to seek or accept help is yours.

- If you believe that someone has interfered with your right to register or decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Voter Registration Coordinator, 50 Branch Avenue, Providence, RI 02904 or (401)222-2345.

Rhode Island Voter Registration Form

Official use for barcode

This form is for: ☐ New voter ☐ Update my information ☐ Party change

! Eligibility

If you check **"No"** in response to any of these questions, do not complete this form.

Are you a citizen of the United States? ☐ Yes ☐ No

Are you a resident of Rhode Island? ☐ Yes ☐ No

Are you at least 16 years of age? ☐ Yes ☐ No *You must be 18 years old to vote.*

Personal Information

All fields on this form are required except when indicated as optional.

Phone/email is optional and is public record.

Last Name | Suffix

First Name | Middle Initial

Date of Birth (mm/dd/yyyy) | Phone/Email (optional)

Identification Numbers

If you have never voted in Rhode Island, please enter the appropriate identification number.

Driver's License and State ID card must be issued by the RI Department of Motor Vehicles.

You may also submit a copy of your identification with this application.

☐ Rhode Island Driver's License or State ID card number: _____

☐ I have not been issued a RI Driver's License or State ID card.
Enter the last 4 digits of your Social Security Number (SSN): _____ _____ _____ _____

☐ I have not been issued a RI Driver's License, State ID card, or a Social Security Number.

Rhode Island Home Address

Home Address (Not a PO Box) | Unit Number

RI

City/Town | State | Zip Code

Mailing Address

If different from Rhode Island Home Address.

Mailing Address | Unit Number

City/Town | State | Zip Code

Party Affiliation

☐ Democrat ☐ Republican ☐ Unaffiliated ☐ Other: _____

Affirmation and Signature

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.

I swear or affirm that:

I am a U.S. Citizen; I live at the address set forth above; I will be at least eighteen (18) years old when I vote; I am not incarcerated in a correctional facility upon a felony conviction; I have not been lawfully judged "mentally incompetent" to vote by a court of law. The information I have provided is true to the best of my knowledge under pains and 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.

SIGN HERE:

X

Date Signed (mm/dd/yyyy)

Update my Information

If you have have changed your name or were already registered to vote in RI or in another state.

Previous Name

Previous Address (County, City/Town, State, Zip Code)

Get Involved!

☐ I am interested in being a poll worker

Return Address

_____

_____

_____

Postage Required

Post Office will not deliver without proper postage.

Mail to: **BOARD OF CANVASSERS**

_____

_____

_____

Barrington Town Hall
283 County Rd. 02806
247-1900 x4

Bristol Town Hall
10 Court St. 02809
253-7000

Burrillville Town Hall
105 Harrisville Main St.
Harrisville 02830
568-4300

Central Falls City Hall
580 Broad St. 02863
727-7450

Charlestown Town Hall
4540 South County Trl. 02813
364-1200

Coventry Town Hall
1670 Flat River Rd. 02816
822-9150

Cranston City Hall
869 Park Ave. 02910
780-3126

Cumberland Town Hall
45 Broad St. 02864
728-2400

East Greenwich Town Hall
125 Main St.,
P.O. Box 111 02818
886-8603

East Providence City Hall
145 Taunton Ave. 02914
435-7502

Exeter Town Hall
675 Ten Rod Rd. 02822
294-2287

Foster Town Hall
181 Howard Hill Rd. 02825
392-9201

Glocester Town Hall
1145 Putnam Pike
P.O. Box B, Chepachet 02814
568-6206 x0

Hopkinton Town Hall
1 Town House Rd. 02833
377-7777

Jamestown Town Hall
93 Narragansett Ave. 02835
423-9804

Johnston Town Hall
1385 Hartford Ave. 02919
553-8856

Lincoln Town Hall
100 Old River Rd.
P.O. Box 100 02865
333-1140

Little Compton Town Hall
40 Commons
P.O. Box 226 02837
635-4400

Middletown Town Hall
350 East Main Rd. 02842
849-5540

Narragansett Town Hall
25 Fifth Ave. 02882
782-0625

Newport City Hall
43 Broadway 02840
845-5386

New Shoreham Town Hall
16 Old Town Rd.
P.O. Box 220 02807
466-3200

North Kingstown Town Hall
100 Fairway Dr, 02852
294-3331 x128

North Providence Town Hall
2000 Smith St. 02911
232-0900 x234

North Smithfield Municipal Annex
575 Smithfield Rd. 02896
767-2200

Pawtucket City Hall
137 Roosevelt Ave. 02860
722-1637

Portsmouth Town Hall
2200 East Main Rd. 02871
683-3157

Providence City Hall
25 Dorrance St. 02903
Room 102
421-0495

Richmond Town Hall
5 Richmond Townhouse Rd.
Wyoming 02898
539-9000 x9

Scituate Town Hall
195 Danielson Pike
P.O. Box 328
North Scituate 02857
647-7466

Smithfield Town Hall
64 Farnum Pike, 02917
233-1000 x116

South Kingstown Town Hall
180 High St.
Wakefield 02879
789-9331 x1231

Tiverton Town Hall
343 Highland Rd. 02878
625-6703

Warren Town Hall
514 Main St. 02885
245-7340

Warwick City Hall
3275 Post Rd. 02886
738-2010

West Greenwich Town Hall
280 Victory Hwy. 02817
392-3800

West Warwick Town Hall
1170 Main St. West Warwick, RI 02893
822-9201

Westerly Town Hall
45 Broad St. Westerly, RI 02891
348-2503

Woonsocket City Hall
169 Main St.
P.O. Box B 02895
767-9221