EOHHS-Ryan White HIV Provision of Care & Special Populations
Virks Building, Suite 227
3 West Rd., Cranston, RI. 02920
Fax: (401) 462-3297

EOHHS Rhode Island Federally Assisted Benefit Program-**RIFAB**-Short form Recertification-

*** For Re-Enrollment purposes only***

The EOHHS, Rhode Island Federally Assisted Benefit Program (RIFAB) for Health Insurance assistance, is one of the services offered by the Rhode Island Ryan White Program. The purpose of the RIFAB program is to pay health insurance premiums on behalf of AIDS Drug Assistance (ADAP) eligible participants. If you have any questions about completing this application, please contact us at (401)462-3294, (401)462-3520(EOHHS), or (855)840-4774 (HSRI main line).

First Name: **MI:**	**My gross family income has NOT changed since my last ADAP recertification** ☐
Full Legal Last Name:	**My household size has NOT changed since last my ADAP recertification** ☐
Social Security Number: - -	**No Changes in insurance coverages since last my ADAP recertification** ☐
Date of Birth:	**I understand that failing to update ADAP of any changes in the above categories could result in tax penalties for myself** ☐
Mailing Address: **Street: _____** **City: _____** **Zip:**	**My enrollment in or eligibility for Medicaid, Medicare, or health insurance (individually or through my employer, spouse, or other individual) has NOT changed since my last ADAP application** ☐
Phone#:_____	**Plan Type:** ☐ **Individual** ☐ **Family**
Last ADAP completion date: _____/_____/_____	**Family Dental Plan:** ☐ **Yes** ☐ **No**

I certify that the information in this application is true and correct as of the date below and I acknowledge that any false, intentional or negligent misrepresentation of the information may result in nullification of this application or immediate termination from the program and liability for money granted. This form will indicate the amount of APTC paid to insurers on the consumer's behalf during the year. Information on this form will also be reported to the IRS. Failure to provide full and accurate information could result in tax penalties that would become the sole obligation of the below signed applicant.

SIGN & DATE THIS FORM:

_____ _____

Signature of Applicant (or legal guardian if unable to sign) **Date**

If mailing, keep a copy of this form for your records and mail the original form and all documents to:

Attn: Denise Cappelli
EOHHS
HIV Provision of Care
Virks Building, Suite 227
3 West Rd., Cranston, RI 02920