General Eligibility Requirements

Eligibility Process

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☐ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

☐ An attachment is submitted.

☐ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

☐ An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

☐ An attachment is submitted.

☒ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

☐ An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

☒ Yes ☐ No
# Medicaid Eligibility

**Indicate the other electronic means below:**

<table>
<thead>
<tr>
<th>Name of Method</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web Portal</td>
<td>Internet access to electronic application</td>
</tr>
</tbody>
</table>

The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

- Parents and Other Caretaker Relatives
- Pregnant Women
- Infants and Children under Age 19

**Redetermination Processing**

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

- ☑ Once every 12 months

☐ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

☐ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☐ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

**Coordination of Eligibility and Enrollment**

The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

---

**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

TN 13-019  
Rhode Island  
Approved: 03/11/2014  
Effective: 10/01/2013
# USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION

<table>
<thead>
<tr>
<th>Paper Application</th>
<th>Online Application</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TRANSMITTAL NUMBER:</strong></td>
<td><strong>STATE:</strong></td>
</tr>
<tr>
<td>13-0019 MM2</td>
<td>Rhode Island</td>
</tr>
</tbody>
</table>

Through December 31, 2014, the state is using an interim alternative single streamlined application. After December 31, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state’s application. The revised application will be incorporated by reference into the state plan.
USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION

<table>
<thead>
<tr>
<th>Paper Application</th>
<th>Online Application</th>
</tr>
</thead>
</table>

**TRANSMITTAL NUMBER:**

| 13-0019 MM2 |

**STATE:**

| Rhode Island |

Through December 31, 2014, the state is using an interim alternative single streamlined application. After December 31, 2014 the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state’s application. The revised application will be incorporated by reference into the state plan.
APPLICATION FOR

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

<table>
<thead>
<tr>
<th>Use this application to see what healthcare coverage you qualify for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Free healthcare coverage from Rhode Island Medicaid or Rite Care</td>
</tr>
<tr>
<td>• Tax credits to help you pay your monthly health insurance bill</td>
</tr>
<tr>
<td>• Private Health Plans</td>
</tr>
</tbody>
</table>

Apply faster online at [www.healthsourceri.com](http://www.healthsourceri.com), [www.dhs.ri.gov](http://www.dhs.ri.gov) or [www.eohhs.ri.gov](http://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.

<table>
<thead>
<tr>
<th>Information you may need to apply:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Social Security numbers</td>
</tr>
<tr>
<td>• Birth dates</td>
</tr>
<tr>
<td>• Passport, alien, or other immigration numbers for any legal immigrants who need healthcare coverage</td>
</tr>
<tr>
<td>• Previous tax returns, income information for all adults and all minors under age 19 who are required to file a tax return</td>
</tr>
<tr>
<td>• Information about health coverage available to your family</td>
</tr>
<tr>
<td>• W-2 Forms</td>
</tr>
<tr>
<td>• 1099 Forms</td>
</tr>
<tr>
<td>• Employer health insurance information, even if you are not covered by your employer’s insurance plan</td>
</tr>
</tbody>
</table>

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:
HealthSource RI
H2D Mailroom
74 West Road, Suite 900
Cranston, RI 02920-8413

Get help with this application:
• Online: [www.healthsourceri.com](http://www.healthsourceri.com), [www.dhs.ri.gov](http://www.dhs.ri.gov) or [www.eohhs.ri.gov](http://www.eohhs.ri.gov)
• Phone: Call the Customer Support Center at 1-855-609-3304 or 1-888-657-3173 (TTY)
• In person: To find in-person application assistance visit [www.healthsourceri.com](http://www.healthsourceri.com), [www.dhs.ri.gov](http://www.dhs.ri.gov) or [www.eohhs.ri.gov](http://www.eohhs.ri.gov) or visit 70 Royal Little Drive, Providence RI (Monday through Saturday 8:00 AM to 9:00 PM, Sundays 12:00 noon to 6:00 PM)

Need help with your application? Visit [www.healthsourceri.com](http://www.healthsourceri.com), [www.dhs.ri.gov](http://www.dhs.ri.gov) or [www.eohhs.ri.gov](http://www.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 1-888-627-3173.
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) 619-9403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

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.

---

For help with your application, visit healthsourceri.com, call 1-855-606-3304, or call EOHHS at 1-855-606-3304. For help in a language other than English, call 1-855-606-3304 and tell the customer service representative the language you need. We'll get you help at no cost. TTY users should call 1-888-657-3173.
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 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 Reinstatement 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 EO-HHS 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.
# 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 girlfriend or boyfriend) 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

<table>
<thead>
<tr>
<th>1. First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Suffix (Sr., Jr., I, II, III, IV)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Gender</th>
<th>3. Date of Birth</th>
<th>4. Are you applying for Medical coverage?</th>
<th>5. Are you applying for Dental coverage?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ M</td>
<td>Month: __________ Day: ___ Year: ___</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>□ F</td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Do you have a Social Security number?</th>
<th>7. My Name is different on my Social Security card?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

If you have an SSN, enter it here.

6a. Social Security number (SSN):

<table>
<thead>
<tr>
<th>7a. If YES, Name on Card:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>8. First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Suffix (Sr., Jr., I, II, III, IV)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. Gender</th>
<th>10. Date of Birth</th>
<th>11. Is this person applying for Medical coverage?</th>
<th>12. Is this person applying for Dental coverage?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ M</td>
<td>Month: __________ Day: ___ Year: ___</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>□ F</td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13. Does this person have a Social Security number?</th>
<th>14. Is this person’s name different on his or her Social Security card?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

If this person has an SSN, enter it here.

13a. Social Security number (SSN):

<table>
<thead>
<tr>
<th>14a. If YES, Name on Card:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>15. First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Suffix (Sr., Jr., I, II, III, IV)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>16. Gender</th>
<th>17. Date of Birth</th>
<th>18. Is this person applying for Medical coverage?</th>
<th>19. Is this person applying for Dental coverage?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ M</td>
<td>Month: __________ Day: ___ Year: ___</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>□ F</td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>20. Does this person have a Social Security number?</th>
<th>21. Is this person’s name different on his or her Social Security card?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

If this person has an SSN, enter it here.

20a. Social Security number (SSN):

<table>
<thead>
<tr>
<th>21a. If YES, Name on Card:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>22. First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Suffix (Sr., Jr., I, II, III, IV)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>23. Gender</th>
<th>24. Date of Birth</th>
<th>25. Is this person applying for Medical coverage?</th>
<th>26. Is this person applying for Dental coverage?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ M</td>
<td>Month: __________ Day: ___ Year: ___</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>□ F</td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>27. Does this person have a Social Security number?</th>
<th>28. Is this person’s name different on his or her Social Security card?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

If this person has an SSN, enter it here.

27a. Social Security number (SSN):

<table>
<thead>
<tr>
<th>28a. If YES, Name on Card:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

---

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
   - [ ] Portugués

4a. **Preferred written language (lenguaje escrito preferido)**
   - [ ] English
   - [ ] Español
   - [ ] Portugués

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
   - [ ] Chippewa
   - [ ] 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:______

---

*NEED HELP WITH YOUR APPLICATION? Visit healthsourceri.com, dhisr.gov or call 1-866-667-3364. Para obtener una copia de este formulario en Español, llame 1-866-667-3364. If you need help in a language other than English, call 1-866-609-3504 and tell the customer service representative the language you need. We'll get you help at no cost. TYT users should call 1-888-607-3173.*
### 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.*

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Document Type</th>
<th>Document Type</th>
<th>Document Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>13a. Certificate of Citizenship: Alien #:</td>
<td>Citizenship Number</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>13b. Naturalization Certificate: Alien #:</td>
<td>Naturalization Number</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>13c. Reentry Permit (I-327): Alien #:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13d. Permanent Resident Card (&quot;Green Card,&quot; I-551): Alien #:</td>
<td>I-551 Card Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13e. Refugee Travel Document (I-571) Alien #:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13f. Employment Authorization Card (I-766) Alien #:</td>
<td>I-776 Card Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13g. Machine Readable Immigrant Visa (with temporary I-551 language): Visa Number:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alien Number:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13h. Temporary I-551 Stamp (on passport or I-94, I-94A) Alien Number:</td>
<td>Passport Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13i. Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services</td>
<td>I-94 Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13j. Arrival/Departure Record in unexpired foreign passport (I-94) Sevis ID:</td>
<td>Passport Number:</td>
<td>I-94 Number:</td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visa Number:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13k. Unexpired foreign passport Country of Issuance: Sevis ID:</td>
<td>Passport Number:</td>
<td>I-94 Number:</td>
<td></td>
</tr>
<tr>
<td>Visa Number:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13l. Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)</td>
<td>Passport Number:</td>
<td>I-94 Number:</td>
<td></td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13m. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) Sevis ID:</td>
<td>Passport Number:</td>
<td>I-94 Number:</td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13n. Other documents or status types Document Description: Alien Number:</td>
<td>Passport Number:</td>
<td>I-94 Number:</td>
<td></td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

First Name  Middle Name  Last Name

---

NEED HELP WITH YOUR APPLICATION? Visit healthsource.gov, submit your application, or call us at 1-855-663-3354. Para obtener una copia de este formulario en Español, llame al 1-855-663-3354. If you need help in another language, call 1-855-663-3354 and tell the customer service representative the language you need. We'll get you help at no cost. TTY users should call 1-888-657-3173.
**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**: 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 (SSDI)?  
   - 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)?  
   - Yes  
   - No  
   **If NO**, skip to question 22.

21a. Do you currently work as an employee for a business or an organization?  
   - Yes  
   - No  
   **If NO**, skip to question 22.

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

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 □
   - Profit □ Loss □
   - 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:

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

<table>
<thead>
<tr>
<th>Deductions</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type:</td>
<td>Weekly Every 2 Weeks Monthly Yearly</td>
</tr>
<tr>
<td>Type:</td>
<td>Weekly Every 2 Weeks Monthly Yearly</td>
</tr>
<tr>
<td>Type:</td>
<td>Weekly Every 2 Weeks Monthly Yearly</td>
</tr>
<tr>
<td>Type:</td>
<td>Weekly Every 2 Weeks Monthly Yearly</td>
</tr>
</tbody>
</table>

**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  ☐ Husband/Wife  ☐ Son/daughter  ☐ Parent
   ☐ Uncle/aunt  ☐ Domestic Partner  ☐ Stepson/stepdaughter  ☐ Stepparent
   ☐ First cousin  ☐ Former spouse  ☐ Nephew/niece  ☐ Guardian
   ☐ Brother-in-law/sister-in-law  ☐ Adopted son/daughter  ☐ Grandparent  ☐ Grandparent
   ☐ Son  ☐ Foster child  ☐ Parent’s domestic partner
   ☐ Daughter  ☐ Sponsored dependent

   ☐ Other relative caretaker

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
   ☐ 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

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.

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Document Number</th>
<th>Expiration (MM/DD/YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>13a. Certificate of Citizenship: Alien #:</td>
<td>Citizenship Number</td>
<td>Not applicable</td>
</tr>
<tr>
<td>13b. Naturalization Certificate: Alien #:</td>
<td>Naturalization Number</td>
<td>Not applicable</td>
</tr>
<tr>
<td>13c. Reentry Permit (I-327): Alien #:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13d. Permanent Resident Card (&quot;Green Card&quot;, I-551):</td>
<td>I-551 Card Number:</td>
<td></td>
</tr>
<tr>
<td>13e. Refugee Travel Document (I-571)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13f. Employment Authorization Card (I-768)</td>
<td>I-776 Card Number:</td>
<td></td>
</tr>
<tr>
<td>13g. Machine Readable Immigrant Visa (with temporary I-551 language).</td>
<td>Passport Number:</td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alien Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13h. Temporary I-551 Stamp (on passport or I-94, I-94A)</td>
<td>Passport Number:</td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alien Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13i. Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services</td>
<td>I-94 Number:</td>
<td></td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13j. Arrival/Departure Record in unexpired foreign passport (I-94)</td>
<td>Passport Number:</td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visa Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13k. Unexpired foreign passport</td>
<td>Passport Number:</td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13l. Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)</td>
<td>Passport Number:</td>
<td></td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13m. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)</td>
<td>Passport Number:</td>
<td></td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13n. Other documents or status types</td>
<td>Passport Number:</td>
<td></td>
</tr>
<tr>
<td>Document Description:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alien Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
</tr>
</thead>
</table>

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

16. Is this person a member of a Federally Recognized Tribe?  □ Yes  □ No  **If NO, skip to question 18.**

**Family Member 2 - Disability and Disability Services Information**

18. Is this person physically ill, incapacitated, blind, or disabled?  □ Yes  □ No

19a. Will this disability prevent this person from working at least 12 months, or result in death?  □ Yes  □ No

19b. Is this person active with the Office of Rehabilitation Services or Services for the Blind?  □ Yes  □ No

19c. Has this person applied for SSI or Social Security Benefits (SSI)?  □ Yes  □ No

19d. 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?  □ Yes  □ No

If YES: Expected Graduation Date: Month:_____ Day:_____ Year:_______

Parent Outside the Home Information (Optional): This question only applies to applicants under the age of 18.  □ Yes  □ No

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.

---

*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:

22e. Employer Address:

22g. Wages/Tips Frequency:
   □ Hourly □ Daily □ Weekly □ Every 2 Weeks □ Monthly □ Yearly

22f. Wages/Tips before Taxes:

22i. Employer Identification Number:

22j. Employer Address:

22l. Wages/Tips Frequency:

23. Does this person receive self-employment income?
   □ Yes □ No

   Status: □ Profit □ Loss

   If YES, amount of Rent or Royalty Income: ____________

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

24. Capital Gains/Investment income (or losses) □ Yes □ No

24a. Status: □ Profit □ Loss

24c. Frequency: □ Weekly □ Every 2 Weeks □ Monthly □ Yearly

24e. Wages/Tips Frequency:

25. Dividends:

25c. Frequency: □ Weekly □ Every 2 Weeks □ Monthly □ Yearly

25d. Income from Partnerships Corporations and Trusts:

26. Farming/Fishing Income

26c. Frequency: □ Weekly □ Every 2 Weeks □ Monthly □ Yearly

27. Unemployment

28. Social Security Disability Income (SSDI)
   Do not include Supplemental Security Income (SSI) Income or any Veterans’ disability benefits.
   □ Yes □ No

28a. Status: □ Profit □ Loss

28c. Frequency: □ Weekly □ Every 2 Weeks □ Monthly □ Yearly

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

30. Alimony/Spousal Support

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).

32. 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.

   □ Yes □ No

   Status: □ Profit □ Loss

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

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

Need help with your application? Visit healthsource.org, and select “Apply.” If you need help in a language other than English, call 1-855-609-3304 and tell the customer service representative the language you need. We’ll get you help at no cost. TTY users should call 1-888-667-3173.
**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:

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

<table>
<thead>
<tr>
<th>Deductions</th>
<th>How much ($)</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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
   - [ ] 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

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.

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Document Number</th>
<th>Expiration (MM/DD/YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>13a. Certificate of Citizenship: Alien #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13b. Naturalization Certificate: Alien #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13c. Reentry Permit (I-327): Alien #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13d. Permanent Resident Card (“Green Card,” I-551): Alien #</td>
<td></td>
<td>I-551 Card Number:</td>
</tr>
<tr>
<td>13e. Refugee Travel Document (I-571)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13f. Employment Authorization Card (I-766)</td>
<td></td>
<td>I-776 Card Number:</td>
</tr>
<tr>
<td>13g. Machine Readable Immigrant Visa (with temporary I-551 language): Visa Number:</td>
<td></td>
<td>Passport Number:</td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alien Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13h. Temporary I-551 Stamp (on passport or I-94, I-94A)</td>
<td></td>
<td>Passport Number:</td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alien Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13i. Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services</td>
<td></td>
<td>I-94 Number:</td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13j. Arrival/Departure Record in unexpired foreign passport (I-94)</td>
<td></td>
<td>Passport Number:</td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td>I-94 Number:</td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visa Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13k. Unexpired foreign passport</td>
<td></td>
<td>Passport Number:</td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td>I-94 Number:</td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13l. Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)</td>
<td></td>
<td>Passport Number:</td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td>I-94 Number:</td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13m. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)</td>
<td></td>
<td>Passport Number:</td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td>I-94 Number:</td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13n. Other documents or status types</td>
<td></td>
<td>Passport Number:</td>
</tr>
<tr>
<td>Document Description:</td>
<td></td>
<td>I-94 Number:</td>
</tr>
<tr>
<td>Alien Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
</tr>
</thead>
</table>

---

**NEED HELP WITH YOUR APPLICATION?** Visit healthcare.gov or askhhs.gov or call us at 1-855-603-3394. Para obtener una copia de este formulario en Español, llame 1-855-603-3394. If you need help in a language other than English, call 1-855-603-3394 and tell the customer service representative the language you need. We’ll get you help at no cost. TTY users should call 1-888-657-3173.
### 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: 17a. 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 (SSDI)?  □ 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?  □ Yes  □ No

If YES: Expected Graduation Date: Month:  Day:  Year:

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
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: ________
22d. Employer Address: _____________________________
   City _____________________________ State __________ Zip Code __________
22f. Wages/Tips before Taxes: __________
   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: __________
   Wages/Tips Frequency:
   □ Hourly □ Daily □ Weekly □ Every 2 Weeks □ Monthly □ Yearly

23. Does this person receive self-employment Income? □ Yes □ No
   □ Profit □ Loss

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
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

   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:**

<table>
<thead>
<tr>
<th>Deduction</th>
<th>Health Savings Account (HSA) Contributions</th>
<th>IRA/401K Deductions</th>
<th>Self-employment Tax Deductions</th>
<th>Self-employment Retirement Plans and Self-employment Health Insurance</th>
<th>Business Expenses of performing artists, reservists, and fee-basis government officials</th>
<th>Moving Costs related to a job change</th>
<th>Domestic Product Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alimony Paid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest Paid on Student Loans</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educator Expenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuition and School Fees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deductions</th>
<th>How much ($)</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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? $**
<table>
<thead>
<tr>
<th>1. First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Suffix (SR., Jr., I, II, III, IV)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
   - □ 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

7. Race (Optional)
   - □ American Indian or Alaska Native
   - □ Native Hawaiian or 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.

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Document Number</th>
<th>Expiration (MM/DD/YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>13a. Certificate of Citizenship: Alien #:</td>
<td>Citizenship Number</td>
<td>Not applicable</td>
</tr>
<tr>
<td>13b. Naturalization Certificate: Alien #:</td>
<td>Naturalization Number</td>
<td>Not applicable</td>
</tr>
<tr>
<td>13c. Reentry Permit (I-327): Alien #:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13d. Permanent Resident Card (&quot;Green Card,&quot; I-551):</td>
<td>I-551 Card Number:</td>
<td></td>
</tr>
<tr>
<td>Alien #:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13e. Refugee Travel Document (I-571)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alien #:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13f. Employment Authorization Card (I-766)</td>
<td>I-776 Card Number:</td>
<td></td>
</tr>
<tr>
<td>Alien #:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13g. Machine Readable Immigrant Visa (with temporary I-551 language).</td>
<td>Passport Number:</td>
<td></td>
</tr>
<tr>
<td>Visa Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alien Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13h. Temporary I-551 Stamp (on passport or I-94, I-94A)</td>
<td>Passport Number:</td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alien Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13i. Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services</td>
<td>I-94 Number:</td>
<td></td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13j. Arrival/Departure Record in unexpired foreign passport (I-94)</td>
<td>Passport Number:</td>
<td>I-94 Number:</td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visa Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13k. Unexpired foreign passport</td>
<td>Passport Number:</td>
<td>I-94 Number:</td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13l. Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)</td>
<td>Passport Number:</td>
<td>I-94 Number:</td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13m. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)</td>
<td>Passport Number:</td>
<td>I-94 Number:</td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13n. Other documents or status types</td>
<td>Passport Number:</td>
<td>I-94 Number:</td>
</tr>
<tr>
<td>Document Description:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alien Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sevis ID:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of Issuance:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
</tr>
</thead>
</table>

---

**NOTICE:** Use of this form is optional. The information you provide is protected by the Health Insurance Portability and Accountability Act (HIPAA) and is confidential. We are required to protect your personal and medical information as specified by HIPAA. Your information will only be used by the following.

- [ ] Medicaid
- [ ] Medicare
- [ ] Commercial Insurers
- [ ] Other health care programs

For further assistance, visit the California Department of Public Health. To report a privacy violation, call 1-800-538-1253.

**Important:** If you have a question about this information, call 1-800-538-1253.

**Helpful Resources:**
- [ ] Visit the Health Benefits website [here](https://www.healthbenefits.gov)
- [ ] Call 1-800-538-1253 for assistance
- [ ] Email your questions to [email](mailto:healthbenefits@healthcare.gov)

**Insurance Information:**
- [ ] Health Benefits
- [ ] State Health Benefits
- [ ] Federal Health Benefits

**Health Care Provider Information:**
- [ ] Group Health Plan
- [ ] Private Health Plan
- [ ] Federal Health Plan

**Health Care Facility Information:**
- [ ] Hospital
- [ ] Urgent Care Center
- [ ] Doctor's Office

**Important Note:** If you are receiving care from a health care provider, please provide the following information:

- [ ] Name of the health care provider
- [ ] Address of the health care provider
- [ ] Phone number of the health care provider

---

**Helpful Links:**
- [ ] Privacy Notice
- [ ] Security Notice
- [ ] State Health Benefits
- [ ] Federal Health Benefits

**Important:** If you have a question about this information, call 1-800-538-1253.
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Is this person an honorably discharged veteran or an active duty member in the U.S. military?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Is this person American Indian or an Alaskan Native?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>If YES: 17a. Is this person a member of a Federally Recognized Tribe?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>If YES: 17b. Tile Name</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>17a. Has this person ever gotten service from the Indian Health Service, Tribal Health Program or Urban Indian Health Program?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Family Member 4 - Disability and Disability Services Information**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>18a. Will this disability prevent this person from working at least 12 months, or result in death?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>18b. Is this person active with the Office of Rehabilitation Services or Services for the Blind?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>18c. Has this person applied for SSI or Social Security Benefits (RSDI)?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>18d. Does this person need help with the activities of daily living?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Family Member 4 - Additional Questions**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>20. If this person is under 19 years old, is this person a full time student?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>If YES: Expected Graduation Date: Month:_____ Day:____ Day Year:____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Outside the Home Information (Optional): This question only applies to applicants under the age of 18.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>21. Does this child have a parent living outside the home?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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.

---

Photocopy this sheet to add additional employers for the primary applicant

---

NEED HELP WITH YOUR APPLICATION? Visit healthsourceri.com, call 1-855-605-5334, or call us at 1-855-533-3333. Para obtener una copia de este formulario en Español, llame 1-855-605-3334. If you need help in a language other than English, call 1-855-605-3334 and tell the customer service representative the language you need. We'll get you help at no cost. TTY users should call 1-888-657-3173.
### Family Member 4 - Income

22. Does this person receive employment income (wages/salaries/tips)?
   - Yes □ Yes □ No

If NO, skip to question 23.

22a. Does this person currently work as an employee for a business or an organization?
   - Yes □ 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?
   - Yes □ Yes □ No

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 □ Yes □ No

If YES, amount of Rent or Royalty Income: ________


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): ________
25b. Net Capital Gains (profit after subtracting capital losses):
   - Frequency: □ Weekly □ Every 2 Weeks □ Monthly □ Yearly

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

27. Unemployment: ________
   - Frequency: □ Weekly □ Every 2 Weeks □ Monthly □ Yearly

   - 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

**NEED HELP WITH YOUR APPLICATION? Visit healthinsured.com, dial 911 or call 1-855-609-3304. If you need help in a language other than English, call 1-855-609-3304 and tell the customer service representative the language you need. We'll get you help at no cost. TTY users should call 1-888-657-3173.**

25
**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:

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

**Deductions**

<table>
<thead>
<tr>
<th>Type:</th>
<th>How much ($)</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Weekly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Every 2 Weeks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yearly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type:</th>
<th>How much ($)</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Weekly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Every 2 Weeks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yearly</td>
</tr>
</tbody>
</table>

**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:
   - [ ] Single filing taxes
   - [ ] Married filing taxes separately
   - [ ] Married filing jointly

3a. Name of Tax Filer

3b. If Filing Jointly – Please indicate the other joint taxpayer:

   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
   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:
   [ ] Contact Email Address
   [ ] Contact Phone Number

4. Name of person eligible for this employer insurance on this application:
   4a. Enrollment Status
      [ ] Enrolled Now
      [ ] Plans to Enroll
      [ ] Not Enrolled
      Start Date (MM/DD/YYYY)
   4b. Upcoming Changes to Your Plan
      [ ] 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
      [ ] Enrolled Now
      [ ] Plans to Enroll
      [ ] Not Enrolled
      Start Date (MM/DD/YYYY)
   5b. Upcoming Changes to Your Plan
      [ ] 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
      [ ] Enrolled Now
      [ ] Plans to Enroll
      [ ] Not Enrolled
      Start Date (MM/DD/YYYY)
   6b. Upcoming Changes to Your Plan
      [ ] 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
      [ ] Enrolled Now
      [ ] Plans to Enroll
      [ ] Not Enrolled
      Start Date (MM/DD/YYYY)
   7b. Upcoming Changes to Your Plan
      [ ] 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:

9. 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/his/her 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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Name</th>
<th>Name</th>
</tr>
</thead>
</table>

### 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

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
</table>

### 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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
</table>

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*

---

*NEED HELP WITH YOUR APPLICATION? Visit healthconnector.com, dss.ca.gov or enroll.hi.gov or call us at 1-855-663-3394. For obtener una copia de este formulario en Español, llame 1-855-663-3394. If you need help in a language other than English, call 1-855-609-3394 and tell the customer service representative the language you need. We'll get you help at no cost. TTY users should call 1-888-657-3373.*
## 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
   - Cell  
   - Other  
   - Work
   ( )

1c. Secondary Phone Number
   - Cell  
   - Other  
   - Work
   ( )

1d. Email Address

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

1f. What is the preferred time of contact?  
   - Morning  
   - Afternoon  
   - Evening  
   - Weekend  
   - Anytime

1g. Preferred spoken language (lengua hablada preferida)
   - English  
   - Español  
   - Portugués

1h. Preferred written language (lengua escrita preferida)
   - English  
   - Español  
   - Portugués

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**: 

---

## 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)
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-HSRH (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, 29-3-23, 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
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 changes 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 1-855-640-4774.
- 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

HealthSource RI
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF HUMAN SERVICES

NEED HELP WITH YOUR APPLICATION? Visit healthsourceRI.com, dhpri.gov or call 1-855-600-3304. Para obtener una copia de esta formulación en Español, llame 1-855-600-3304. If you need help in a language other than English, call 1-855-600-3304 and tell the customer service representative the language you need. We'll get you help at no cost. TTY users should call 1-888-627-3173.
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.)

<table>
<thead>
<tr>
<th>Family Member - Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does this person receive employment income (wages/salaries/tips)?</td>
</tr>
<tr>
<td>If NO, skip to question 4.</td>
</tr>
<tr>
<td>1a. Does this person currently work as an employee for a business or an organization?</td>
</tr>
<tr>
<td>If NO, skip to question 4.</td>
</tr>
<tr>
<td>If this person is currently employed, please complete the following information about his/her employer and income.</td>
</tr>
<tr>
<td>2. Employer 1 Name:</td>
</tr>
<tr>
<td>2b. Employer Address:</td>
</tr>
<tr>
<td>If this person has another employer, please complete the following information on that employer and income.</td>
</tr>
<tr>
<td>3. Employer 1 Name:</td>
</tr>
<tr>
<td>3b. Employer Address</td>
</tr>
<tr>
<td>Status: ☐ Profit ☐ Loss</td>
</tr>
</tbody>
</table>

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):**

   2c. **Dividends:**

   2d. **Income from Partnerships, Corporations, and Trusts:**

   3. **Farming/Fishing Income:** Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Yearly

   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):**

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

   7. **Alimony/Spousal Support:**

   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):**

### 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:

<table>
<thead>
<tr>
<th>Deductions</th>
<th>How much ($)</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alimony Paid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest Paid on Student Loans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educator Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuition and School Fees</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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? $
Rhode Island
Voter Registration Form

You may use this form to:
- Register to vote in Rhode Island.
- Change your name and/or address on your registration.
- Choose a political party or change parties.

To register to vote in RI you must be:
- A legal resident of Rhode Island.
- A citizen of the United States.
- At least 16 years of age.

(You must be at least 18 years of age to vote on Election Day.)

Instructions

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

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

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

Box 6: If you want to affiliate to vote, choose a party. If you leave Box 9 blank, you will be listed as unaffiliated.

Box 7: You must sign and date the registration form. If you fail to sign and date the form, it will be returned to you.

Box 10: If you are updating your voter registration because you legally changed your name, enter your previous legal name.

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

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

(This form may be reproduced)

1. Check boxes that apply:
   - New Voter Registration  [ ]
   - Address Change  [ ]
   - Party Change  [ ]
   - Name Change  [ ]

2. I am a U.S. Citizen and resident of Rhode Island.
   - Yes  [ ]
   - No  [ ]

   I am at least 16 years of age.
   - Yes  [ ]
   - No  [ ]

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

3. RI driver's license or ID Number:

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

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

4. Last Name  [ ]
   Suffix (if any)  [ ]

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

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

7. Date of Birth (mm/dd/yyyy)  [ ]

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

9. Party Affiliation:
   - Democrat  [ ]
   - Republican  [ ]
   - Unaffiliated  [ ]
   - Other  [ ]

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

11. Previous Name (if different from Box 4)  [ ]

12. Previous Address of Registration (City/Town, State, ZIP & County)  [ ]

Official Use For Barcode

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

Date:  [ ]
Signed  [ ]

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.

900812 Reg
Form Revised 12/2012
Mail To: BOARD OF CANVASSERS

INSTRUCTIONS FOR MAILING THE VOTER REGISTRATION FORM

An applicant who chooses to mail his/her voter registration form shall do so in the following manner:
1. Fold the form at the dotted line and tape the bottom to the top of the form.
2. From the list below, locate the address of the board of canvassers in the city or town in which you are registering to vote and insert that address in the appropriate space beneath "Mail To: BOARD OF CANVASSERS" on the addressed side of the voter registration form. Insert your return address in the space provided.

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

LOCAL BOARDS OF CANVASSERS

Barrington Town Hall, 283 County Rd., Barrington, RI 02806
Bristol Town Hall, 10 Court St., Bristol, RI 02809
Burrisville Town Hall, 105 Harrisville Main St., Harrisville, RI 02830
Central Falls City Hall, 889 Broad St., Central Falls, RI 02863
Charlestown Town Hall, 4546 S. County Trail, Charlestown, RI 02813
Coventry Town Hall, 1670 Flat River Rd., Coventry, RI 02816
Cranston City Hall, 869 Park Ave., Cranston, RI 02910
Cumberland Town Hall, 45 Broad St., Cumberland, RI 02864
East Greenwich Town Hall, PO Box 111, East Greenwich, RI 02816
East Providence City Hall, 7 Taunton Ave., East Providence, RI 02914
Exeter Town Hall, 575 Ten Rod Rd., Exeter, RI 02822
Foster Town Hall, 161 Howard Hill Rd., Foster, RI 02828
Gloucester Town Hall 1145 Putnam Pike PO Drawer B, Gloucester, RI 02814
Hopkinton Town Hall, 1 Town House Rd., Hopkinton, RI 02833
Jamestown Town Hall, 83 Narragansett Ave., Jamestown, RI 02835
Johnston Town Hall, 1386 Hartford Ave., Johnston, RI 02919
Lincoln Town Hall, 100 Old River Rd., PO Box 100, Lincoln, RI 02865
Little Compton Town Hall, PO Box 226, Little Compton, RI 02837
Middletown Town Hall, 300 East Main Rd., Middletown, RI 02842
Narragansett Town Hall, 25 Fifth Ave., Narragansett, RI 02882
New Shoreham Town Hall, PO Drawer, 220 Block Island, RI 02807
Newport City Hall, 45 Broadway, Newport, RI 02840
North Providence Town Hall, 200 Smith St., North Providence, RI 02911
North Smithfield Municipal Annex, 576 Smithfield Rd., North Smithfield, RI 02896
Pawtucket City Hall, 137 Roosevelt Ave., Pawtucket, RI 02860
Portsmouth Town Hall, 2200 East Main Rd., Portsmouth, RI 02871
Providence City Hall, 25 Dorrance St., Providence, RI 02903
Richmond Town Hall, 5 Richmond Townhouse Rd., Rhode Island 02899
Scituate Town Hall, PO Box 326, North Scituate, RI 02857
Smithfield Town Hall, 64 Farmhouse Pike, Smithfield, RI 02917
S. Kingstown Town Hall, 180 High St., Wakefield, RI 02879
Tiverton Town Hall, 345 Highland Rd., Tiverton, RI 02878
Warren Town Hall, 514 Main St., Warren, RI 02885
Warwick City Hall, 3275 Post Rd., Warwick, RI 02886
West Greenwich Town Hall 200 Victory Highway, West Greenwich, RI 02817
West Warwick Town Hall, 1170 Main St., West Warwick, RI 02893
Westerly Town Hall, 45 Broad St., Westerly, RI 02891
Woonsocket City Hall, P.O. Box 8, Woonsocket, RI 02895

Voter Registration Questions May Be Addressed To:
Rhode Island Board of Elections
50 Branch Avenue
Providence, RI 02904
elections@elections.ri.gov