# RI Affordable Health Care Coverage Assistance Program

## (Parent/Caretaker Premium Assistance)

Starting in February 2014, parents of Medicaid eligible children with annual household incomes under 175% of the federal poverty level (FPL) will be eligible for assistance to pay a portion of their monthly premium if they choose a silver plan from HealthSource RI.

The amount of assistance from the State to help pay the monthly premium is shown in the chart below:

| | 138% FPL to 150% FPL | | 151% FPL to 175% FPL | |
|---|---|---|---|---|
| **Family Size** | **Monthly Reimbursement for income less than this amount:** | | **Monthly Reimbursement for income between this amount:** | |
| 2 | $39 | $26,130 | $28 | $26,131 - $30,485 |
| 3 | $49 | $32,940 | $43 | $32,941 - $38,430 |
| 4 | $59 | $39,750 | $58 | $39,751 - $46,375 |
| 5 | $69 | $46,560 | $73 | $46,561 - $54,320 |
| 6 | $79 | $53,370 | $88 | $53,371 - $62,265 |

## Directions:

Please complete the attached form to request reimbursement. The State will check with HealthSource RI to see if the monthly premium payment has been made, on a monthly basis, and will send you a check.

## Frequency Asked Questions:

**When I apply online at HealthSource RI, will I see the amount of this assistance deducted from the total monthly premium I will owe?**

No. The amount will not show up online. The State is working to incorporate this online at a later date.

**If I receive federal Tax Credits, can I still get this State Assistance?**
Yes, if you select a silver plan.

**When do I have to send in the form?**

Please complete the form as soon as you sign up for health coverage at HealthSource RI.

Mail this form to: EOHHS/RIte Share
Virks Bldg.
3 West Road
Cranston, RI 02920

Fax: (401) 462-6337

**Do I have to fill out a form every month to receive payment?**
No, just once.

**When will I receive payment?**
Once the State is able to verify that we have received your form, you meet the program requirements, and have paid your monthly premium, we will send you your reimbursement.

**Who do I call if I have questions about the State Assistance Program?**

Please call RIte Share at (401) 462-0311.

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## Application for State-funded Assistance to Pay for Health Care Coverage

**Directions:** To receive help paying for your health insurance, please fill out this form and mail it to the address below. We will reimburse you for part of your monthly premium. The amount is based on your income and family size.

Name:_______________________________________________

Address: ____________________________________________

_________________________________________________

Date of birth: __________________________

Last 4-digits of Social Security number: ____________________________

Name of health plan selected (silver plan):__________________________________________

Telephone number (day time): ________________________________

I attest that the information on this form is true.

____________________________________________ _________________________
Name of person applying (signature) Date

**Mail this form to:** EOHHS/RIte Share, Virks Bldg., 3 West Road, Cranston, RI 02920