



Rite Care/Rite Share Application

Please complete this application (pages 1-10). **The Department of Human Services will determine if you qualify for Rite Care or Rite Share. We will notify you to let you know what program you are in.**

Rite Care is RI’s health insurance program for families where you receive health care through a participating Rite Care Health Plan (Neighborhood Health Plan, United Healthcare, or Blue CHIIP).

Rite Share is RI’s health insurance premium assistance program where you enroll in your employer (or your spouse’s employer) health insurance plan. Rite Share pays all or part of your share of the premium cost for family coverage. You will also receive a Medical Assistance card for services not covered by your employer’s health plan.



This envelope indicates that you must send additional information with your completed application. If you need help with this application, please call 462-1300 or 462-5300.

1. APPLICANT NAME (Head of Household)			Social Security Number*	
Last	First	Initial		
YOUR PHONE NUMBER		<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
		<input type="checkbox"/> Separated	<input type="checkbox"/> Single	
ADDRESS	Street	City/Town	State	Zip Code
MAILING ADDRESS (If different)				

*If you do not have a social security number, you must get one. This will not delay your application.

2. Do you or any adult in your household speak English? Yes No

If no, what language is spoken in your home? _____

You must tell us about the citizenship and immigration status of anyone who is applying for Rite Care/Rite Share. You must also give us your social security number if you have one. You may give us this information voluntarily for anyone listed in your household who is not applying for health benefits. If you do, we can only use this information to verify your family’s income and help us decide the best way to provide health benefits to the eligible members of your family. We will not give the information in this application to anyone else, including the Immigration and Naturalization Service (INS).

- 3. Your household.** List the following people who live with you: • **YOURSELF** • **YOUR SPOUSE** • **CHILDREN**
- Include the parents of all children who are applying, even if the parents are not married
 - Include stepparents of children applying
 - Include relative caregivers, if parents are not living with their children


NAME Last	First	Initial	HOW IS THIS PERSON RELATED TO YOU?	FEMALE OR MALE?	DATE OF BIRTH month / day / year	ARE YOU APPLYING FOR THIS PERSON?	SOCIAL SECURITY NUMBER (if you have one)	U.S. CITIZEN?	RACE/ETHNIC GROUP (voluntary)
			SELF/ Head of Household	<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

4. Please write the name and immigration status for each person applying for Rlte Care or Rlte Share who is not a US citizen. Rlte Care is available for pregnant women and children under age 19 regardless of immigration status or citizenship.

NAME	Last	First	Initial	IMMIGRATION STATUS

IMMIGRATION STATUS

1. Legal permanent residents	5. Granted conditional entry
2. Admitted as refugees	6. Paroled into the US for at least 1 year
3. Granted asylum	7. Cuban/Haitian entrant
4. Granted withholding of deportation	8. Temporary visitors visa (write type, if known)
	9. Other (includes all other documented or undocumented immigration statuses)

 IF YOUR IMMIGRATION STATUS IS # 1–8 (above) proof of immigration status is needed. However, we will not delay the processing of the application for pregnant women or children while waiting for proof of immigration status. Please send a copy of your “green card”, work permit, passport or other immigration papers with the application. Please copy both sides of the card.

IF YOUR IMMIGRATION STATUS IS # 9 (above) proof of immigration status and RI residency at some time prior to 7/1/97 is required for all adults applying for health benefits (except pregnant women). Pregnant women and children in #9 “Other”, do not need to send proof of immigration status or RI residency.

5. Is anyone who is applying for Rlte Care or Rlte Share between 17 and 19 years old and in high school? Yes No
 Parents of 18 year olds (who are still in school) may be eligible for Rlte Care/Rlte Share.

NAME	Last	First	Initial	EXPECTED DATE OF GRADUATION
SCHOOL				<input type="checkbox"/> Full Time <input type="checkbox"/> Half Time <input type="checkbox"/> Less than Half Time

6. Is anyone in your household pregnant? Yes No

HER NAME	Last	First	Initial	Is this pregnancy covered by health insurance?	When is the baby due?
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

 Please send a copy of proof of pregnancy showing the baby’s due date (for example, a letter from your doctor or other health care provider).

7. Do the children you are applying for have both of their parents living with them? Yes No

If no, write information you have about the parent who is not living in the household. We will use this information to seek a court order for medical support against the absent parent. If you believe that you or your child would suffer physical or emotional harm if we contacted the absent parent, you can ask us not to pursue a court order for medical support action.

ABSENT PARENT'S NAME Last First Initial		IS THE ABSENT PARENT DECEASED? If yes, date of death: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Female <input type="checkbox"/> Male	SOCIAL SECURITY NUMBER	IS THE ABSENT PARENT DISABLED AND/OR A VETERAN? <input type="checkbox"/> Yes <input type="checkbox"/> No
DATE OF BIRTH	PHONE NUMBER	ABSENT PARENT'S CURRENT MARITAL STATUS: <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown
ADDRESS		WERE THE PARENTS OF THE CHILD(REN) MARRIED TO EACH OTHER? If yes, date married: <input type="checkbox"/> Yes <input type="checkbox"/> No
EMPLOYER'S NAME AND ADDRESS		ARE THE PARENTS OF THE CHILD(REN) MARRIED TO EACH OTHER NOW? If no, date divorced: <input type="checkbox"/> Yes <input type="checkbox"/> No
ABSENT PARENT'S CHILDREN IN YOUR HOUSEHOLD:		

ABSENT PARENT'S NAME Last First Initial		IS THE ABSENT PARENT DECEASED? If yes, date of death: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Female <input type="checkbox"/> Male	SOCIAL SECURITY NUMBER	IS THE ABSENT PARENT DISABLED AND/OR A VETERAN? <input type="checkbox"/> Yes <input type="checkbox"/> No
DATE OF BIRTH	PHONE NUMBER	ABSENT PARENT'S CURRENT MARITAL STATUS: <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown
ADDRESS		WERE THE PARENTS OF THE CHILD(REN) MARRIED TO EACH OTHER? If yes, date married: <input type="checkbox"/> Yes <input type="checkbox"/> No
EMPLOYER'S NAME AND ADDRESS		ARE THE PARENTS OF THE CHILD(REN) MARRIED TO EACH OTHER NOW? If no, date divorced: <input type="checkbox"/> Yes <input type="checkbox"/> No
ABSENT PARENT'S CHILDREN IN YOUR HOUSEHOLD:		

8. Are you or any other adults in your household employed? Yes No

If yes, write in the income your household receives from the job. Check whether the employer offers health insurance and if employed adult is a U.S. citizen or a qualified immigrant. We will use this information to verify income and to decide whether to contact the employer to see if the employer's health plan can be approved for the Rite Share Premium Assistance Program. Coverage through a Rite Share approved employer plan can only be required if an employed parent(s) or caregiver relative of a child applying is a U.S. citizen or a qualified immigrant. (Qualified immigrant statutes are listed on page 3, number 1-8.) No employer contact will be made if the employed adult is not a U.S. citizen or qualified immigrant.

If an employed parent is eligible to enroll the family in a Rite Share approved employer health plan and refuses to do so, any eligible children applying will be enrolled in Rite Care. Any adults in the household applying for health benefits will be denied eligibility for six months.

WORKER'S NAME Last First Initial	AMOUNT EARNED
EMPLOYER NAME AND ADDRESS	\$ _____ <input type="checkbox"/> every week <input type="checkbox"/> every 2 weeks <input type="checkbox"/> every month <input type="checkbox"/> other: _____
Employer offers health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is worker a U.S. citizen or qualified immigrant? <input type="checkbox"/> Yes <input type="checkbox"/> No*	

WORKER'S NAME Last First Initial	AMOUNT EARNED
EMPLOYER NAME AND ADDRESS	\$ _____ <input type="checkbox"/> every week <input type="checkbox"/> every 2 weeks <input type="checkbox"/> every month <input type="checkbox"/> other: _____
Employer offers health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is worker a U.S. citizen or qualified immigrant? <input type="checkbox"/> Yes <input type="checkbox"/> No*	

WORKER'S NAME Last First Initial	AMOUNT EARNED
EMPLOYER NAME AND ADDRESS	\$ _____ <input type="checkbox"/> every week <input type="checkbox"/> every 2 weeks <input type="checkbox"/> every month <input type="checkbox"/> other: _____
Employer offers health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is worker a U.S. citizen or qualified immigrant? <input type="checkbox"/> Yes <input type="checkbox"/> No*	

*If no, DHS will not contact your employer to verify health insurance



Please include copies of pay stubs for the last 4 weeks (one month).

9. Does anyone in your household have a claim or suit pending for illness or injuries from an accident, Workers' Compensation or other source? Yes No

If yes, write name of person: _____

10. Write in the total amount of income you or any adult in your household receive(s) from self-employment, child care income or rental income.


TYPE OF INCOME	GROSS INCOME	HOW OFTEN	EXPENSES	WILL THIS INCOME CONTINUE?	NAME OF PERSON WHO EARNS THIS MONEY
SELF-EMPLOYED INCOME	\$		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
CHILD CARE INCOME	\$		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
RENTAL INCOME	\$		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

 For each type of income listed above, include proof of gross income earned and related expenses, if any.

11. Do you or any adult in your household have any other income? Yes No

List all other income below. These are a few examples. Use the "other" category for types of income not listed.

INCOME	AMOUNT	HOW OFTEN	WILL THIS INCOME CONTINUE?	NAME OF THE PERSON WHO GETS THIS MONEY
UNEMPLOYMENT COMPENSATION	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
TEMPORARY DISABILITY INSURANCE	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
CHILD SUPPORT	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
ALIMONY	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
WORKERS' COMPENSATION	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
VETERANS ADMINISTRATION BENEFITS	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
SOCIAL SECURITY PAYMENT	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
SOCIAL SECURITY PAYMENT	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
INTEREST INCOME	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
OTHER (please explain)	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

 Please send a copy of proof of income you receive. (For example, check or award letter.)

12. Does anyone in your household pay for child care? Does anyone in your household pay for someone to take care of a disabled adult in your home? Yes No

NAME OF PERSON PAYING FOR CARE	NAME OF CHILD OR ADULT RECEIVING CARE	WILL THIS COST CONTINUE?	AMOUNT PAID FOR CARE *	HOW OFTEN
		<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	

* including any DHS child care subsidy

13. Is anyone in your household covered by other health or dental insurance? Yes No
 If **YES**, write the name of the person with the insurance and other information below.

POLICY HOLDER NAME			HEALTH OR DENTAL INSURANCE COMPANY NAME	
POLICY NUMBER		GROUP NUMBER		
TYPE OF COVERAGE <input type="checkbox"/> Family <input type="checkbox"/> Individual		IF YOU PAY A PREMIUM: \$ PER		DATE POLICY BEGAN
IS INSURANCE EMPLOYER SPONSORED? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, NAME OF EMPLOYER PROVIDING INSURANCE:				
NAMES OF ALL PEOPLE COVERED				

POLICY HOLDER NAME			HEALTH OR DENTAL INSURANCE COMPANY NAME	
POLICY NUMBER		GROUP NUMBER		
TYPE OF COVERAGE <input type="checkbox"/> Family <input type="checkbox"/> Individual		IF YOU PAY A PREMIUM: \$ PER		DATE POLICY BEGAN
IS INSURANCE EMPLOYER SPONSORED? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, NAME OF EMPLOYER PROVIDING INSURANCE:				
NAMES OF ALL PEOPLE COVERED				

If you need more room to answer questions, please use the other side. Be sure to write the number of the question.

DECLARATIONS OF APPLICANT

MEDICAL SUPPORT AND ESTABLISHMENT OF PATERNITY—Assignment of Rights: I understand that by signing below I am assigning to DHS and Child Support Enforcement (CSE) rights to pursue and receive medical support from the parent of a child under age 18. Cooperation: I know that I am required to cooperate with CSE in pursuing this support, but I have the right to claim good cause if I refuse to cooperate. (RItE Care/ RItE Share cannot be denied to eligible children because of their parent's refusal to establish paternity or secure support from absent parents.) I understand that pregnant women are not required to cooperate in establishing paternity and securing medical support for an unborn child.

AMOUNTS RECOVERABLE FROM A THIRD PARTY—I know that RItE Care or RItE Share does not pay medical expenses that a third party, such as a private health insurance company, is supposed to pay. I understand that by signing below, I am giving my rights to any third party payments to DHS. These payments may include payments from hospital and health insurance policies, or may result from a lawsuit or other claim.

LIEN ON DECEASED RECIPIENT'S ESTATE—I understand that medical assistance paid through RItE Care or RItE Share for a recipient aged fifty-five (55) years or older is a debt to the State and shall constitute a lien upon the recipient's estate in favor of DHS. (However, the lien shall not apply to the estate of a recipient who is survived by a spouse, a child under age twenty-one (21) or a child who is blind or permanently and totally disabled.)

PENALTIES FOR PERJURY—I understand that I am breaking the law if I give wrong information, and can be punished under federal law, state law or both.

YOUR RIGHTS

HEALTH CARE BENEFITS

I know that I have the RIGHT to request, and if found eligible, to receive Medical Assistance (RItE Care or RItE Share) benefits based on policies and standards established under Rhode Island law.

CONFIDENTIALITY

I know that the information I have given is confidential. DHS uses information about me and my family only for purposes directly related to the administration of the RItE Care or RItE Share program. These uses include sending certain information to my RItE Care Health Plan, and to the RI Public Transit Authority if I request a bus pass. I agree that my RItE Care Health Plan may release information about my family's medical care to DHS for purposes directly related to the administration of the RItE Care or RItE Share program, and I know that this information, too, is confidential. Other than as indicated, DHS does not release information about RItE Care/RItE Share members or applicants without their consent, except as required by law.

RIGHT TO APPEAL

I know that I have the RIGHT to appeal and to receive a prompt hearing before a DHS Appeals Officer if I am dissatisfied with any DHS decision, or if DHS delays in making a decision. I may be represented by a lawyer or any other person I select. I must request a hearing in writing within 30 days from the date I receive a written notice regarding my RItE Care or RItE Share eligibility.

HEALTH PLAN COMPLAINTS

I know that I have the RIGHT to complain about my medical treatment or denial of medical services by my RItE Care Health Plan. Each Health Plan has a grievance and appeals process for these complaints. If I am not satisfied with my Health Plan’s decision after the appeal process, I can contact the RItE Care/RItE Share Info Line. If I am still not satisfied, I may file a complaint with the Division of Facilities Regulation, RI Department of Health, 3 Capitol Hill, Providence, RI 02908, telephone number (401) 222-2566.

NON-DISCRIMINATION

I know that my eligibility will not be affected by my race, color, national origin, disability, sex, age, religion, or sexual orientation, except where this is restricted by law. I know that I have the RIGHT to refuse to provide information about my racial/ethnic heritage, and that such refusal will not affect my eligibility for RItE Care or RItE Share.

OTHER ELIGIBILITY

I understand that this application is only for RItE Care or RItE Share. I understand that if I am not found eligible for RItE Care or RItE Share by means of this application, I may be eligible for Medical Assistance benefits on some other basis. I understand I may also be eligible for other programs administered by DHS, such as food stamps or cash assistance. I understand that to apply for other forms of Medical Assistance or for other DHS programs, I would be required to use a different application form and submit additional documentation.

YOUR RESPONSIBILITIES

ACCURACY I agree to give DHS accurate information to prove the statements I have made, and I give DHS permission to get such proof.

NOTIFICATION OF CHANGES I agree to tell DHS immediately (within 10 days) of any changes in information on this form.

COOPERATION WITH AUDITS I agree to cooperate fully with State and Federal personnel conducting quality control reviews and medical record audits.

SOCIAL SECURITY NUMBERS I agree to furnish a valid Social Security number for myself and every member of my household who has one, or to apply for them if they are entitled to one.

SIGN HERE

*I CERTIFY that all of my answers in this application are true and complete.
I have read and understand my Declarations, Rights and Responsibilities that are printed above.*

_____	_____
SIGNATURE OF APPLICANT	DATE
_____	_____
SIGNATURE OF SPOUSE, IF LIVING IN HOUSEHOLD	DATE
_____	_____
SIGNATURE OF PERSON HELPING YOU COMPLETE THIS FORM/AGENCY ID CODE	DATE

NON-DISCRIMINATION NOTICE

The Rhode Island Department of Human Services (DHS) does not discriminate on the basis of race, color, national origin, disability, political beliefs, sexual orientation, age, religion, or sex in acceptance for or provision of services, employment or treatment, in its educational and other programs and activities. For more information about these laws, or on procedures for resolution of complaints of discrimination, contact DHS at 600 New London Avenue, Cranston, RI 02920, 462-2130 (TDD 462-6239).

APPLICANT NAME/ HEAD OF HOUSEHOLD	Last	First	Initial	SOCIAL SECURITY NUMBER	PHONE NUMBER
-----------------------------------	------	-------	---------	------------------------	--------------

1. CHOOSE A HEALTH PLAN Each family must choose one of the available Health Plans listed.

<input type="checkbox"/>  1-800-963-1001 TDD 459-6105	<input type="checkbox"/>  1-800-587-5187 TDD 587-5188	<input type="checkbox"/>  1-800-564-0888 TDD 459-5505
---	---	---

2. LIST YOUR HOUSEHOLD MEMBERS THAT ARE APPLYING FOR RITE CARE OR RITE SHARE. If you already have a doctor, list his or her name below. If you do not have a doctor, your health plan will help you choose one when you become a member.

NAME	Last	First	Initial	DATE OF BIRTH	SOCIAL SECURITY NUMBER	PREGNANT?	DOCTOR	DOCTOR'S LOCATION (CITY OR TOWN)
Head of Household				month / day / year		<input type="checkbox"/> Yes <input type="checkbox"/> No	(Primary Care Provider)	
						<input type="checkbox"/> Yes <input type="checkbox"/> No		
						<input type="checkbox"/> Yes <input type="checkbox"/> No		
						<input type="checkbox"/> Yes <input type="checkbox"/> No		
						<input type="checkbox"/> Yes <input type="checkbox"/> No		
						<input type="checkbox"/> Yes <input type="checkbox"/> No		

FOR OFFICE USE

AGENCY NAME / AGENCY ID _____ DATE _____

3. SIGN AND DATE _____ DATE _____
 APPLICANT



RIte Care, RIte Share or Medical Assistance Application /Recertification Supplement for Citizenship and Identity Verification

Federal law now requires U.S. citizens who apply for or receive RIte Care, RIte Share or Medical Assistance (except those receiving SSI or Medicare) to show proof of their citizenship and identity. **For new applicants, you must show proof of citizenship and identity before you can become eligible. You must do this within 30 days of application. For current recipients, you must show proof when you recertify. You will only have to provide this proof once.**

If you are 16 or older, you can prove your citizenship and identity by showing:

Your passport **OR** certificate of naturalization **OR** Birth certificate **AND** either a driver’s license or state photo ID or school photo ID

For children under 16 years old, you can prove citizenship and identity by showing:

Your passport **OR** certificate of naturalization **OR** Birth certificate **AND** parent’s signature below proving identity for children under 16 years old

Other documents may also be acceptable to prove citizenship and identity. A complete list of acceptable documents is on the back of this form. If you don’t have these documents, start the process now because it may take several weeks to get them. Bring in the documents you do have, even if you are missing documents for some family members, so your application or recertification is not delayed for other family members.

You will be required to submit original documents to your local DHS office or to a Family Resource Counselor (FRC). FRCs help people apply and recertify for RIte Care, RIte Share or Medical Assistance. They are located at health centers and some hospitals and community based agencies. Call the Rhode Island Health Center Association at (401) 274-1771 x 201 to find a Family Resource Counselor near you.

Directions: Parents or guardians must complete this form if you are applying or recertifying for RIte Care, RIte Share or Medical Assistance for children under the age of 16. Completing this section will provide proof of identity for children under the age of 16. You will still need to submit a document to prove citizenship (such as a birth certificate). Family members who are 16 years of age or older will have to submit proof of citizenship AND identity to be eligible. See the back of this form for a complete list of documents.

Head of Household First and Last Name	Date of Birth	Social Security number

First and Last Name of Children Under 16 years of Age	Date of Birth	City and State of Birth

Under penalty of perjury, I attest to the identity of the minor children listed above. 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 of Parent or Guardian

Date

Acceptable Citizenship and Identity Documents for Medical Assistance, RIte Care or RIte Share

Federal Law now requires U.S. Citizens who apply for or receive Medical Assistance, RIte Care or RIte Share to show proof of their citizenship and identity.

You can prove your citizenship and identity (primary level) with a U.S. Passport, Certificate of Naturalization or Certificate of U.S. Citizenship OR If you don't have a U.S. Passport, Certificate of Naturalization or Certificate of U.S. Citizenship, you must submit ONE identity document and ONE citizenship document from the list below.

Identity Documentation

- Driver's license with photo
- School I.D. card with photo
- U.S. military card or draft record
- I.D. card issued by federal, state or local government with photo
- Military dependent's I.D. card
- Native American Tribal document
- U. S. Coast Guard Merchant Mariner card
- Certificate of Degree of Indian Blood or other U. S. American Indian/Alaskan Native tribal document with photo
- For children under age 16 - parent or guardian signature verifying child's identity and place of birth

Second Level Citizenship Documentation

- U.S. birth certificate (If you were born in RI, you may obtain your birth certificate from the city/town hall in which you were born, from the city/town hall where you resided at birth, or from the State Office of Vital Records. For more information, log on to www.health.ri.gov or call 222-2811. If you were born outside of RI, you can call 1.866.441.NCHS or log on to <http://www.cdc.gov/nchs/howto/w2w/w2welcom.htm>)
- A Certificate of Report of Birth (DS-1350)
- A report of a Birth Abroad of a U.S. Citizen (FS-240)
- Certificate of birth issued by the Department of State (FS-545 or DS-1350)
- U.S. Citizen I.D. Card (I-197)
- Northern Mariana I.D. Card (I-873)
- American Indian Card (I-872) with KIC code
- Final Adoption decree with child's name and U.S. place of birth
- Evidence of U.S. Civil Service employment before 6/1/1976
- U.S. Military Record showing U.S. place of birth

Third Level Citizenship Documentation

- Hospital record created at time of birth showing U.S. place of birth
- Life, health or other insurance record showing U.S. place of birth that was created at least 5 (five) years prior to application for Medical Assistance/RIte Care/RIte Share

Fourth Level Citizenship Documentation (only to be used in rare circumstances)

- Federal or state census record showing U.S. Citizenship or U.S. place of birth
- One of the following documents that shows a U.S. place of birth and was created at least 5 (five) years prior to application for Medical Assistance/RIte Care/RIte Share
 - Seneca Indian tribal census
 - Bureau of Indian Affairs Tribal census record for Navajo Indians
 - U.S. State Vital Statistics official notification of birth registration
 - An amended U.S. public birth record that is amended more than 5 (five) years after the person's birth
 - Statement signed by physician or midwife who was in attendance at the time of birth
 - Medical (clinic, doctor or hospital) record—does not include immunization record
- Institutional admission papers from a nursing facility, skilled care facility or other institution
- Written affidavit from 2 (two) different people (one person can't be related to applicant and each must show proof of their own identity and citizenship)

For more information, contact your health plan (UnitedHealthcare 1-800-587-5187, Neighborhood Health Plan of RI 1-800-459-6019, Blue Cross Blue Shield of Rhode Island, 401-274-3500 or 1-800-564-0888) or the DHS Infoline at 462-5300.