MA-28 English
REV. 05/18

DEPARTMENT OF HEALTH
MEDICAID PROGRAM

INCOME VERIFICATION BY EMPLOYER

_____
Date

Dear Mr. or Mrs. _____

_____
Company Name

The person identified below has requested the Medicaid benefits, and told us work for your company. For the purposes of determining eligibility for these benefits, please confidentially, report to us, the revenue bearing this person. Please fill out the information requested below completely. If you have any doubt or question call us to the phone: _____.

Medicaid Official Signature: _____

Name of the Applicant:

To be fill by the Company

Company Name:				
Company Address:				
				Tel.
Employee works: ☐ Full Time ☐ Part Time				
Total Weekly Hours:				
Position:			Time as employee:	
Please, enter the salary of the current month and the last three months *(4 months in total)*				
Income	**Current Month**	**Month**	**Month**	**Month**
Gross Income				
Tips				
Bonus				
Commissions				
Comments:				
All employer that offers false information in this worksheet in other to benefit the person requesting the Medicaid benefits, will be charged and prosecuted for violation of Article 166 of the Puerto Rico Criminal Code.				

_____ _____
Name of the Person who fill this form Position

_____ _____
Signature Date