MA-9 - ENGLISH
REV. 4/17

DEPARTMENT OF HEALTH
MEDICAID PROGRAM

To: Puerto Rico Medicaid Program, declare that:

I, ____

Please write your full name (first, middle initial, last name) in print

applicant and / or beneficiary of the Medicaid Program Puerto Rico ____________________

I certify that the information provided to the Puerto Rico Medicaid Program for obtaining Government Health Plan is correct. I understand that providing false information in order to obtain the benefits granted by the Puerto Rico Medicaid Program is an illegal and fraudulent act that entails the obligation to repay all federal and state funds have been disbursed for me. It also entails the imposition of administrative fines and other penalties that may be imposed by the courts of Puerto Rico. And for the record I sign this document today.

1. It is the obligation of the beneficiary to inform the Puerto Rico Medicaid Program of any changes occurring in his / her Family Unit such as: increase or decrease of income or economic resources, change of residence, if he has other coverage (s) or plan Is) health insurance, changes in family composition (deaths, births), among others. The beneficiary will report the change in any of our Medicaid Program offices on or before 30 days after the change occurred.
2. Any person who commits fraud in order to obtain the benefits granted by the Puerto Rico Medicaid Program may be excluded as a participant and may be referred to the Fraud Unit of the Puerto Rico Medicaid Program, the Office of Legal Advisers Department of Health and / or the State and Federal Department of Justice.

☐ SIGNATURE OF APPLICANT AND / OR ☐ BENEFICIARY

SIGNATURE OF WITNESS

DATE

FAMILY NUMBER

EMPLOYEE NAME

EMPLOYEE SIGNATURE