MA-9-A
Rev. 7/2017

DEPARTMENT OF HEALTH
MEDICAID PROGRAM

To: Puerto Rico Medicaid Program

I, _____

Please write your name (first name, Middle name, Las name, Second Last name)

Certify my household members are the following (including myself):

Person 1: Write the full name of member of your household and check the boxes that apply:	Person 2: Write the full name of member of your household and check the boxes that apply:
☐ **Applicant or Beneficiary** ☐ Spouse ☐ Child under 19 years old (0-18 years old) ☐ Child under 20 to 21 years old (19-20 years old) ☐ Parent - Father ☐ Parent - Mother ☐ Stepfather ☐ Stepmother ☐ Brother or Sister underage ☐ Stepbrother or stepsister underage ☐ Other	☐ **Applicant or Beneficiary** ☐ Spouse ☐ Child under 19 years old (0-18 years old) ☐ Child under 20 to 21 years old (19-20 years old) ☐ Parent - Father ☐ Parent - Mother ☐ Stepfather ☐ Stepmother ☐ Brother or Sister underage ☐ Stepbrother or stepsister underage ☐ Other
Person 3: Write the full name of member of your household and check the boxes that apply:	Person 4: Write the full name of member of your household and check the boxes that apply:
☐ **Applicant or Beneficiary** ☐ Spouse ☐ Child under 19 years old (0-18 years old) ☐ Child under 20 to 21 years old (19-20 years old) ☐ Parent - Father ☐ Parent - Mother ☐ Stepfather ☐ Stepmother ☐ Brother or Sister underage ☐ Stepbrother or stepsister underage ☐ Other	☐ **Applicant or Beneficiary** ☐ Spouse ☐ Child under 19 years old (0-18 years old) ☐ Child under 20 to 21 years old (19-20 years old) ☐ Parent - Father ☐ Parent - Mother ☐ Stepfather ☐ Stepmother ☐ Brother or Sister underage ☐ Stepbrother or stepsister underage ☐ Other

I CERTIFY that all the information offered to the Puerto Rico Medicaid Program to obtain the Government Health Plan is correct. I understand that offering false information for the purpose of obtaining the benefits granted by the Puerto Rico Medicaid Program constitutes an illegal and fraudulent act that entails the obligation to return all federal and state funds that have been disbursed in my favor. In addition, it entails the imposition of administrative fines and other penalties that could be imposed by the courts or local or federal administrative agencies.

1. It is the obligation of the beneficiary to inform the Puerto Rico Medicaid Program of any change that occurs in their Family Nucleus such as: increase or decrease of income or economic resources, change of residence, if they have other coverage (s) or plan (is) medical insurance, changes in family composition (deaths, births), among others. The beneficiary will report the change at any of our Medicaid Program offices within 30 days after the change occurred.
2. Any person who commits fraud or abuse 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, to the Office of Legal Advisors of the Department of Health and / or the Department of State and Federal Justice.

_____ _____

☐ Signature of the Applicant, beneficiary or
☐ Authorized Representative

Witness Signature

Date: _____

Household number: _____

Name of the Case Worker: _____

Name of the Case Worker: _____

Note: If more than 4 people live in your home, please use another paper sheet.