MA-9D
Rev. 7/2017

DEPARTMENT OF HEALTH
MEDICAID PROGRAM

I, _____

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

☐ Applicant o ☐ Recipient of the Puerto Rico Medicaid Program **Certify** that the INCOME of each of the people who live in the same house (under the same roof) is as follows:

Person 1: Write the name and surname of the person who lives in the same house and indicate the amount if it applies to you:	Person 2: Write the name and surname of the person who lives in the same house and check all that apply:
☐ Gross Income per Month as an Employee (full-time, part-time, or occasional): $ _____	☐ Gross Income per Month as an Employee (full-time, part-time, or occasional): $ _____
☐ Gross Income per Month for Bonuses (includes Christmas Bonus), Tips, Commissions: $ _____	☐ Gross Income per Month for Bonuses (includes Christmas Bonus), Tips, Commissions: $ _____
☐ Gross Income per Month for Retirement Pension, Annuities, Retirement Account, etc.: $ _____	☐ Gross Income per Month for Retirement Pension, Annuities, Retirement Account, etc.: $ _____
☐ Gross Income per Month from Social Security: $ _____	☐ Gross Income per Month from Social Security: $ _____
☐ Net Income per Month from Self-Employed or own business: $ _____	☐ Net Income per Month from Self-Employed or own business: $ _____
☐ Net Income per Month for Agricultural work or business: $ _____	☐ Net Income per Month for Agricultural work or business: $ _____
☐ Income in the Month due to Unemployment: $ _____	☐ Income in the Month due to Unemployment: $
☐ Money per Month for Ex-spouse Pension: $	☐ Money per Month for Ex-spouse Pension: $
☐ Money in the Month as a Jury: $	☐ Money in the Month as a Jury: $
☐ Money received in the Month for a Lawsuit, Claim, Agreement or Transaction, Retroactive Payment of Employment/ Work or Social Security, etc.: $	☐ Money received in the Month for a Lawsuit, Claim, Agreement or Transaction, Retroactive Payment of Employment/ Work or Social Security, etc.: $
☐ Money received in the Month for Prizes, Games of Chance, Lottery Prizes, etc.: _____	☐ Money received in the Month for Prizes, Games of Chance, Lottery Prizes, etc.: _____
☐ Net Income per Month for Property Rent: _____	☐ Net Income per Month for Property Rent: _____
☐ Net Income per Month for Royalties (Author): _____	☐ Net Income per Month for Royalties (Author): _____
☐ Veterans Administration Monthly Income:	☐ Veterans Administration Monthly Income:
☐ Monthly Income for Alimony: _____	☐ Monthly Income for Alimony: _____
☐ Other Income received per month for _____: amount: _____	☐ Other Income received per month for _____: amount: _____

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.

1. 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.

_____ _____

Firma ☐ Solicitante, ☐ Beneficiario o ☐ Representante Autorizado — Firma del Testigo

Fecha: _____ Núm. de Núcleo Familiar: _____

Nombre del Certificador: _____ Firma del Certificador: _____