MA-9-C
Rev. 7/2017

DEPARTMENT OF HEALTH
MEDICAID PROGRAM

To: Medicaid Program

I, _____

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

Beneficiary or recipient of the Puerto Rico Medicaid Program certify:

☐ That my Social Security number is: | | | | / | | | / | | | | |

Social Security Number

And that I do not have any of the following documents as evidence of it:

1. Social Security Card
2. Employment stub
3. Communication (Correspondence) Official of the Social Security Administration
4. Medicare card if the primary insured is the applicant (This will change in the future)
5. W-2 Form
6. 480 Form
7. Puerto Rico Income Tax Return
8. Form 1040 PR – IRS - Income Tax Return

☐ And that I cannot provide evidence of a social security number for the following reasons:

- ☐ Refuse to get a number due to religious reasons
- ☐ Is a newborn
- ☐ Received Refugee Cash Assistance
- ☐ Have applied for a Social Security number and are in the process of obtaining one.
- ☐ The person is ineligible to obtain a Social Security number
- ☐ He is a child removed by the Department of the Family
- ☐ She is a victim of domestic violence - Office of the Ombudsman for Women.
- ☐ He's a homeless person
- ☐ Ex Con
- ☐ Mental Health Patient

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

_____ _____

CASE WORKER NAME

CASE WORKER SIGNATURE