MA-49
REV. 9/25

DEPARTMENT OF HEALTH
MEDICAID PROGRAM

APPENDIX ON PERMISSIONS, RIGHTS, AND RESPONSIBILITIES OF THE APPLICANT OR BENEFICIARY

INSTRUCTIONS: This annex is an integral part of the benefits application (MA-1) or the recertification form, and a copy must be kept in the corresponding file. The applicant, beneficiary, or their authorized representative must complete each of the four (4) sections included in this document. Upon completion, they must sign and record the date of the signature.

INITIALS	PERMISSIONS, RIGHTS, AND RESPONSIBILITIES OF THE APPLICANT OR BENEFICIARY
	I, _____, by means of this document, give my express consent to the Medicaid Program of the Department of Health to request, use, disclose, or receive protected health information related to myself. This authorization is intended to ensure the continuity of Medicaid Program coverage and includes, among other things, purposes related to treatment, payment, and healthcare operations. Furthermore, I acknowledge and accept that my information may be shared with third parties, who may use it according to their respective purposes, without necessarily being subject to the privacy provisions applicable to the Medicaid Program. This authorization will remain valid for one year from the date of signature. I understand that if I wish to revoke this authorization, I must do so through written notification addressed to the Medicaid Program. However, such revocation will not have retroactive effect on information already disclosed prior to its cancellation. By signing, I certify that I have received guidance from the Medicaid Program regarding its privacy practices, that I have read and understood the terms of this authorization, and that I freely give my consent for the use and disclosure of my health information as stated herein. Let me know if you'd like this adapted for a specific form layout or translated into legal English for official documentation.
INITIALS	**ACKNOWLEDGMENT OF PRIVACY PRACTICES NOTICE AND CONSENT**
	By means of this document, I certify that I have received the Medicaid Program's Notice of Privacy Practices, in accordance with the Health Insurance Portability and Accountability Act (HIPAA). By signing, I acknowledge that I have been informed of the provisions contained in said notice and that I understand the rights and responsibilities related to the privacy of my health information.
INITIALS	**ASSIGNMENT OF RIGHTS AND AUTHORIZATION FOR THE EXCHANGE OF INFORMATION**
	By means of this document, I assign to the Medicaid Program of the Department of Health any right to reimbursement, compensation, or recovery of improper payments related to insurance premiums or other medical expenses incurred personally or on behalf of any member of my household under my care. I also commit to cooperating with officials from the Department of Health and the Medicaid Anti-Fraud Unit in all necessary actions for the identification, management, and recovery of improperly disbursed funds. I understand that, in accordance with current federal regulations, I must provide my Social Security number and the Social Security numbers of all members of my household as a requirement for applying for Medicaid Program benefits. I authorize the Medicaid Program to use the information provided and share it with state and federal public agencies, as well as private entities, for the purpose of verifying household income and resources. This authorization includes, but is not limited to, allowing the Medicaid Program to: • Request my tax information from the Department of Treasury • Access my income information through the Department of Labor • Verify my income and household composition with the Department of Family or any other agency, office, or public instrumentality with relevant authority Furthermore, I understand and accept that the Medicaid Program may conduct inquiries into my credit history or that of the members of my household through agencies authorized for such purposes.

	Let me know if you'd like this formatted for a formal document or adapted for a specific audience.
INITIALS	**LEGAL WARNINGS AND PROHIBITIONS**
	By means of this document, I acknowledge that I have been notified and understand that any alteration, modification, inclusion of issue or expiration dates, or reproduction of the Government of Puerto Rico Health Plan Card for the purpose of fraudulently obtaining services constitutes a violation of the law. I further declare that no individual is authorized to purchase, acquire, or use a Government Health Plan Card without having been certified as eligible by the Medicaid Program. I understand and accept that the transfer or lending of said card to third parties is prohibited by law, and that only the eligible beneficiary whose name appears on the card is authorized to use it.
INITIALS	**STATEMENT OF OBLIGATION AND CHANGE NOTIFICATION**
	By means of this document, I acknowledge and accept that it is my responsibility to inform the Puerto Rico Medicaid Program of any changes that occur within my household, including but not limited to: • Increase or decrease in income • Changes in financial resources • Change of residence • Acquisition of new health insurance coverage or plans • Variations in household composition, such as births or deaths • Any other change that affects the structure of the household I understand that I have a period of thirty (30) days from the date the change occurs to notify the Medicaid Program, and that I may do so through any of its offices, by postal mail, or by email.

CERTIFICATION AND CONSENT STATEMENT: By means of this document, I certify that I am aware of and understand the permissions granted to the Puerto Rico Medicaid Program regarding the use and disclosure of my information, as well as the rights and obligations that apply to me. I further declare that all information provided to the Puerto Rico Medicaid Program for the purpose of obtaining the Government Health Plan is truthful, lawful, and accurate.

I authorize the Medicaid Program to contact me using the most effective means, based on the contact information I have provided. I understand that falsifying, altering, or providing false information with the intent to obtain benefits from the Puerto Rico Medicaid Program constitutes an illegal and fraudulent act, which may result in the obligation to repay all state and federal funds improperly disbursed in my favor.

Additionally, I acknowledge that such actions may lead to the imposition of administrative fines and other legal penalties, in accordance with applicable laws, regulations, and provisions.

Printed Name of the Applicant or Beneficiary

Signature of the Applicant or Beneficiary

Printed Name of the Authorized Representative

Signature of the Authorized Representative

Date