MA-49
REV. 4/24

DEPARTMENT OF HEALTH

MEDICAID PROGRAM

APPENDIX ON RIGHTS, PERMISSIONS AND RESPONSIBILITIES OF THE PARTICIPANT

Instructions: This appendix is part of the application for benefits (MA-1) or recertification form and a copy of it must be kept on file. The applicant, beneficiary, or their authorized representative must initiate each of the four (4) sections of this document and at the end must sign, fill out their contact information, and date it.

Initial	PERMISSIONS, RIGHTS & RESPONSIBILITIES
	PERMISSION TO USE PROTECTED HEALTH INFORMATION I authorize the Department of Health's Medicaid Program to request, use, publish, or receive protected health information about me for continuous coverage, including but not limited to purposes of treatment, payment, and other health care transactions or operations conducted by the Medicaid Program. My information may be shared with third parties, who may use it and who are not covered by the privacy provisions. This permit is valid for one year from my signature. I understand that if I wish to cancel this authorization, I must do so in writing. However, the cancellation will not apply retroactively to previously published information. By signing, I certify that I have been informed by the Medicaid Program on its privacy practices and that I have read the provisions of this permit, that I understand and agree to the terms and conditions AND that I consent to the use and disclosure of my health information as described.
	ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES AND CONSENT I certify that I have received the ***HIPPA Medicaid Notice of Privacy Practices.***
	ASSIGNMENT OF RIGHTS AND EXCHANGE OF INFORMATION I assign to the Medicaid Program any right to reimbursement, remuneration, and recovery of any improper premium payments, or any other improper payments made for medical expenses that I may have, or that any member of my household who is dependent on me, may have. I am committed to working with officials at the Department of Health and the Medicaid Anti-Fraud Unit in any way necessary to identify, manage, and receive improperly provided disbursements. I understand that it is a federal requirement to provide my social security number and the social security number of all members of my household to apply for benefits. I authorize the Medicaid Program to use all information provided with other public agencies (state/federal) or private entities for the purpose of substantiating family income and resources. I understand that this includes, but is not limited to, the Medicaid Program being able to request my tax information from the Treasury Department, my income information from the Department of Labor, and my income and family composition information from the Department of Family or any other related public agency, agency, or instrumentation. At the same time, I understand that the Medicaid Program may inquire about my credit or the credit of a member of my household through an agency authorized for that purpose.
	LEGAL NOTICES AND PROHIBITIONS By signing this document, I acknowledge that I have been notified and understand that altering, modifying, adding issuance or expiration dates, or reproducing in any way the Government of Puerto Rico Health Plan Card to fraudulently obtain services, constitutes a violation of the Law. That no person is authorized to purchase, obtain, or use a Government Health Plan Card without being certified as eligible for Medicaid. That it is prohibited by law to transfer or lend the Government Health Plan Card to another person and that only the eligible beneficiary named on the card is authorized to use it.

Initial	**PERMISSIONS, RIGHTS & RESPONSIBILITIES**
	I acknowledge and understand that it is my obligation to report to the Puerto Rico Medicaid Program any change that occurs in my family unit such as: increase or decrease in income, change in economic resources, change of residence, if I obtain other covered or health insurance plan(s), changes in family composition (deaths or births) and any other change that alters the family. I acknowledge and understand that I **have thirty (30) days from the time the change occurs to report Medicaid and that I may do so by visiting any of the Program's offices, by mail or email, or by facsimile.** I understand that the person who engages in a fraudulent act for the purpose of obtaining the benefits of the Puerto Rico Medicaid Program may be referred to the Anti-Fraud Unit of the Puerto Rico Medicaid Program and/or the State and Federal Department of Justice.

By signing this document, I certify that I know and understand the permissions on the use and publication of my information that I provide to the Program and the rights and duties that apply to me. I certify that all information provided to the Puerto Rico Medicaid Program to obtain the Government Health Plan is legal and correct. By posting my contact information, I authorize the Program to contact me in a manner that is most effective. 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 would entail the obligation to return all federal and state funds that have been disbursed in my favor. In addition, it may impose administrative fines and other penalties that may be imposed in accordance with applicable laws, rules, and regulations.

_____ _____

Name of the Applicant or Beneficiary | Signature of the Applicant or Beneficiary

_____ _____

Authorized Representative's Name | Signature of Applicant Authorized Representative

_____ _____

Date (day/month/year) | Beneficiary's phone number

Residential Address:	Mailing Address:
_____	_____
_____	_____
_____	_____

_____ _____

Caseworker’s Name | Caseworker’s Signature

Puerto Rico's Medicaid Program does not discriminate on the basis of age, race, color, sex, social or national origin, social status, political or religious beliefs, physical or mental disability, or veteran status.