MA-28 English
REV. 05/11

DEPARTMENT OF HEALTH
MEDICAID PROGRAM

INCOME VERIFICATION BY EMPLOYER

_____
Date

Dear Mr. or Mrs. _____

_____
Company Name

The person identified below has requested the Medicaid benefits, and told us work for your company. For the purposes of determining eligibility for these benefits, please confidentially, report to us, the revenue bearing this person. Please fill out the information requested below completely, including relevant discounts. If you have any doubt or question call us to the phone: _____.

Medicaid Official Signature: _____

Name of the Applicant	**Social Security Number**
Family or Application Number:	

To be fill by the Company

Works	☐ Full Time		☐ Part Time				
Position:							
Company Address:							
Phone:			Time employment:				
Please enter the salary and discounts of the last three months. Do not include the Christmas bonus.							
Month & Year	Gross Salary	Social Security	Health Insurance	Income Tax	Disability Insurance	Union	Others Discount
Comments:							

* Please, in the comments section specify the discounts that apply * All employer that offers false information in this worksheet in other to benefit the person requesting the Medicaid benefits, will be charged and prosecuted for violation of Article 166 of the Puerto Rico Criminal Code.

_____ _____
Name of the Person who fill this form | Position

_____ _____
Signature | Date