State of California—Health and Human Services Agency

California Department of Public Health

Income Verification Affidavit

This form is for applicants who are **not** Medi-Cal eligible and (1) have no income, (2), are seasonal workers who work during certain times of the year, (3) are homeless, and/or (4) receive financial support from an agency or an individual who is **not** the applicant's spouse or registered domestic partner (RDP). Applicants who receive financial support from a spouse or RDP should not use this form. This affidavit should **only** be used when one of the criteria above are met and no other income supporting documents are available.

Section 1: Applicant Information (All fields are required unless otherwise noted)

Name (First, M.I. Last): _____

Date of Birth: _____ Client ID Number (optional): _____

Section 2: Please select all that apply

- ☐ a. I have no income and am not Medi-Cal eligible
- ☐ b. I am a seasonal worker and am not Medi-Cal eligible
- ☐ c. I am homeless and am not Medi-Cal eligible
- ☐ d. I am not Medi-Cal eligible, and I receive financial support from someone who is not my spouse or RDP. If check box "d" is selected, "Section 3: Income Support Information" must be completed below.

Section 3: Income Support Information

Complete this section if check box "d" is selected above. This section should be signed by the agency or individual who provides financial support for the applicant.

Select the box that applies:

- ☐ I certify the individual listed below supports me financially, but due to confidentiality reasons I do not authorize the individual to sign this form.
- ☐ I certify that I am not the applicant's spouse or RDP and that I provide financial support to the applicant named above in Section 1.

Please complete this section:

Provider Name: _____ Date: _____

Provider Address: _____

City: _____ State: _____ Zip: _____

Provider Phone: _____ Relationship to Applicant: _____

Provider Representative Signature: _____

Section 4: Certification

By signing this form, I hereby certify that the above information is factual, accurate, complete, and that I have no income source, unless otherwise identified above. I agree to immediately notify CDPH of any changes in my income. I understand that as a condition of participating in the program, CDPH will verify my income with the California Franchise Tax Board. I also understand that CDPH is permitted to request additional income verification if income reported appears to be inconsistent or incorrect. I understand that failure to provide accurate information or deliberately omitting information may result in suspension or termination of services and I may be held financially responsible for any covered services obtained.

Applicant Signature: _____ Date: _____