Sworn Statement of Gift Income

Today's Date: _____

Medi-Cal Access Program

P.O. Box 15559

Sacramento, CA 95852-0559

Dear Medi-Cal Access Program,

I, _____, give _____
(person giving the gift income) (person receiving the gift income)

$ _____ per _____ as a gift.
(amount given) (how often gift is given)

Sincerely,

_____

Signature of person giving the gift income

To be filled out by the person applying for Medi-Cal Access Program:

Name: _____

Address: _____

Phone Number: _____

FMN (If you have it): _____