State of California – Health and Human Services Agency
Department of Health Care Services

For County Use Only

Notice Date: _____
Case Number: _____
Worker Name: _____
Worker ID Number: _____
Worker Phone Number:
_____
Office Hours: _____
Office Address: _____

Request for Additional Income Information for Medi-Cal

To review your Medi-Cal eligibility, we must get this information by: _____

We could not verify the income that was reported to Medi-Cal for _____

This is because our electronic sources, such as tax records, show a different income amount. We need more income information from you to understand why the income does not match. If your income recently changed or varies from month to month, you can choose a reason below to explain.

Reasons

If any of the reasons below apply to you, choose one or more to explain why your income differs from our data sources. If none of the reasons apply, check the last box in the list. Then read **Next Steps** below.

Change in Employment or Income

- ☐ Job loss
- ☐ Self-employed
- ☐ Fluctuating income (Varies from month to month)
- ☐ Decrease in hours
- ☐ Seasonal income (Income only received during part of the year)
- ☐ Working on commission (Paid based on sales)

Change in Household

- ☐ Marriage
- ☐ Divorce

Life Events

- ☐ Victim of identity theft
- ☐ Victim of a natural disaster
- ☐ Domestic violence
- ☐ Homeless

Other

☐ Do not file taxes ☐ Have not yet filed taxes

☐ Other: Please explain below (We may need more information):

☐ None of these reasons apply

Next Steps

After you fill out this form, submit it in one of the ways below.

If you checked "None of these reasons apply" or didn't check a box above, provide proof of your income. The other form you got with the notice tells what income proof is needed. After you provide the proof, your local county office will re-review your Medi-Cal eligibility. They will contact you again if they need more information.

Easy ways to turn in this form or requested proof of income:

Mail:	**Online:**	**In-Person:**	**Phone:**
In the envelope that came with this letter.	At www.coveredca.com or www.benefitscal.com		

Questions?

If you have questions, need more information, or cannot provide the requested proof, please call us at the telephone number listed in the notice.

Privacy Notice

The personal and medical information collected on and with this form is private and confidential. The Department of Health Care Services (DHCS) needs the information to verify your income for Medi-Cal. DHCS will not use or share the information for other purposes except with your permission or as permitted by law. You do not need to return this form to us. If you do not provide all information requested, we cannot verify your income for Medi-Cal. In most cases, the individual(s) to whom this information pertains has the right to access it.

DHCS is authorized to collect this information pursuant to 42 CFR § 435.952. This privacy notice provided here is required by California Civil Code 1798.17.