State of California Health and
Human Services Agency

California Department of Public Health

# Income Verification Affidavit

*This form is to be completed if the **applicant has no income** and is financially supported by an individual other than a spouse/registered domestic partner.*

**Applicant Information**

Applicant Name: _____

Applicant DOB: _____

Client ID Number: _____

**Income Support Information**

*To be completed by the individual providing income support other than the applicant's spouse/registered domestic partner.*

☐ I certify that I provide financial support to the Applicant.

Provider name: _____

Provider Address: _____

City: _____ State: _____ Zip: _____

Provider Telephone Number: _____

Provider relationship to the named applicant above is: _____

Provider Representative Signature: _____

Date: _____

*By signing this form, I hereby certify that the above information is factual, accurate, complete, and that I have no income source. 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 omit information may result in suspension or termination of services and I may be held financially responsible for any covered services obtained.*

**Applicant Signature**: _____ **Date**: _____

"The information requested on this form is required by the (a) California Department of Public Health, Human Resources Branch, Classification, Payroll & Selection Services for purposes of identification and document processing. (d) Furnishing the information requested on this form is mandatory. (f) Information requested on this form is used for benefits processing. (e) Failure to provide the mandatory information may result in benefit enrollment elections not being processed or being processed incorrectly.

(c) Legal references authorizing maintenance of this information include Government Code, Sections 1151 and 1153; Sections 6011 and 6051 of the Internal Revenue Code; and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act. (g) This information may be transferred to other employing state agencies and campuses. (h) Employees have the right to review their own personal information maintained by the California Department of Public Health unless access is exempt by law. (b) Contact the California Department of Public Health, Chief of Human Resources Branch, Classification, Payroll, and Selection Services Section, 1501 Capitol Avenue, Suite 71-1501, P.O. Box 997378, Sacramento, CA 95899-7378, (916) 324-0219."