



Covered California  
 P.O. Box 989725  
 West Sacramento, CA 95798-9725



**COVERED  
 CALIFORNIA**

*Your destination for affordable  
 health insurance, including Medi-Cal*

Case Number:

**Attestation of Income, No Documentation Available**

Please print using CAPITAL LETTERS only

I,

*(first name)*

*(middle name)*

*(last name)*

attest that my household's projected annual income for the benefit year in which I will receive financial assistance for my health plan is

*(annual income)*

\$

- I understand the information provided on this form will only be used to decide if I qualify for financial help. Covered California will keep this information private, as required by law.
  - I understand I must report any income changes to Covered California within 30 days. I understand this may change the amount of financial help I get or the level of cost-sharing I qualify for.
  - I understand this income attestation is only good for the benefit year I'm applying for. I understand I will need to renew my income attestation each year.
  - I understand if I get more tax credits (financial help) than I qualify for, I may need to pay back some or all of the extra amount to the IRS when I file my federal income tax return.
  - I declare, under the penalty of perjury under California law, that the information I've given on this form is true and correct.
- (optional)* Covered California may update my application with the income amount I list on this form. I understand this may change my eligibility for Covered California or financial help, or for the amount of financial help I get. I also understand this new income amount will replace any income information I gave Covered California before, including proof-of-income documents or past attestations.

Applicant's Signature: \_\_\_\_\_

Date:

MM/DD/YYYY

Send your form in one of the following ways:

Electronic Submission  
 For faster processing upload this document directly to your online account at CoveredCA.com

Fax  
 (888) 329-3700

Mail  
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