State of California – Health and Human Services Agency

California Department of Social Services

# INCOME VERIFICATION

COUNTY OF

Notice Date : _____
Case Name : _____
Case Number : _____
Worker Name : _____
Worker Number : _____
Telephone Number: _____
Address : _____
_____
_____

(Addressee)

**YOU MAY LOSE YOUR BENEFITS IF YOU DO NOT RESPOND BY:**

We got information that income was paid to _____ with
(Name)

Social Security Number: _____, who is/was on your case from _____ for
(Date)
the following programs:

☐ CalWORKs (CW) ☐ CalFresh (CF)

**The county does not have a record of you reporting this income information, or it was not reported timely, or was not reported in the correct amount. We must review your past eligibility to make sure you got the correct amount of benefits.**

Additional information:

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We need the following information for: _____
(Name)

☐ Gross pay amounts from _____ to _____
(Date) (Date)

☐ _____ W2 tax form
(Year)

☐ Other: _____

If you cannot get the information we are asking for, please let us know. We may be able to help you get it.

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**Easy Ways to Turn in Your Proof**

- Online: _____
- By mail: _____
- In person: _____
- By phone: _____