Request for Tax Household Information (RFTHI)

Please contact us if you need this form in another language, large print, or other format

How to complete this form:

1. Answer all of the questions on the form. Use ink and print your answers. If you need more space, attach a separate sheet to this form.
2. Read the information about you and each member of your household, including tax dependents. Add any missing information. If any information has changed, write in the correct information.
3. Sign the form on page 3.
4. **Return this form by _____**. Use the postage paid envelope to return the form. If you do not return the form by this deadline, you will lose your Medi-Cal coverage.

What we need:

We need information about each person living in your household or listed on your tax return, including:

- Those who get Medi-Cal now
- Those who do not have Medi-Cal now but would like to apply, and
- Those who live in the household and do not have Medi-Cal but do not want to apply.

If you do not qualify for Medi-Cal:

If you do not qualify for Medi-Cal, we will check to see if you qualify for other kinds of health coverage. We may send your information to another program so they can see if you qualify.

Need Help?:

Call your Medi-Cal Agency at: 1-877 652-0731
TTY: 1-800-952-8349

You can call Monday to Friday 8:00 A.M. – 5:00 P.M.

You must fill out one of these forms for <u>each person</u> in your household and return it to the county to keep your Medi-Cal

Case Number (optional)	SSN or ATIN/ITIN
Individuals' Name	Birth date (mm/dd/yyyy)
Current street address, apartment number	City Zip code
Mailing address, if different from above	City Zip code

1. Is this person: ☐ Employed ☐ Self-Employed
2. If this person is currently employed, list all of the information about all types of income received including:

Employer Name: _____ Employer Address: _____

Employer Phone Number: _____ Average Hours Worked Each Week: _____

Wages/Tips (before Taxes): _____ ☐Hourly ☐ Twice a Month☐ Semi Monthly ☐Monthly☐ Yearly

3. If this person is self-employed, answer the following question:

Type of work: _____

How much net income (profit once business expenses are paid) will you receive from self-employment this month?
_____

4. For this person, do you plan to file a federal income tax return NEXT YEAR? ☐Yes, complete a-c ☐No, skip to c
a. Will you file jointly with a spouse? ☐No ☐Yes, Name of Spouse: _____
b. Will you claim any dependents? ☐No ☐Yes, Name of Dependents _____
c. Will you be claimed as a dependent on someone's tax return? ☐No ☐Yes
If yes, list the name of the tax filer: _____ How is this person related to the tax filer:
_____

5. Please answer the following question only if this person is under the age of 21 and a full time student:

Did this person have health insurance through a job and lose it within the last 12 months? ☐Yes ☐No

6. Were you or anyone else in your family who is age 26 or younger in foster care at the age of 18? ☐Yes ☐No

7. Has this person's immigration or citizenship status changed in the past 12 months?☐ Yes ☐No
If Yes, please explain what changed: _____

8. Is this person: ☐ Hispanic ☐ Latino☐ Spanish☐ American Indian or Alaskan Native ☐ White

☐ Black or African American ☐ Filipino☐ Chinese☐ Japanese☐ Cambodian☐ Korean ☐ Vietnamese

☐ Asian Indian☐Laotian ☐ Other Asian, specify: _____☐ Native Hawaiian

☐ Guamanian or Chamorro☐ Samoan ☐ Other or Mixed Race

9. Renewal of coverage for future years:

To make it easier to determine my eligibility for help applying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I may opt out at any time.

☐ Yes, renew my eligibility automatically for the next:

- ☐ 5 years (the maximum number of years allowed), or for a shorter number of years:
- ☐ 4 years
- ☐ 3 years
- ☐ 2 years
- ☐ 1 year

☐ Don't use information from tax returns to renew my coverage.

**Note: The income/tax filing information is required for all household members. If additional family members are employed or self-employed, questions 1-4 should be answered for these individuals as well.

Your Rights and Responsibilities

- I am signing this renewal form under penalty of perjury. That means that I have provided true answers to all the questions on this form to the best of my knowledge, and I know that I may be subject to penalties under federal law if I provide false or untrue information.
- I know that I must tell Covered California if anything changes and is different from what I wrote on this form. I can call 1-800-300-1506 or visit www.coveredca.com to report any changes. I understand that a change in my information might affect whether someone in my household qualifies for coverage.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file.
- If I think Covered California has made a mistake, I can appeal its decision. To appeal means to tell someone at Covered California that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting Covered California at 1-800-300-1506. Someone from Covered California will explain anything about this application to me if I need that.
- I understand that if I do not qualify for Medi-Cal, Covered California will check to see if I qualify for other kinds of health coverage. Covered California may send my information to another program so they can see if I qualify.

I declare, under penalty of perjury, under the laws of the State of California that all information provided on this form is true and correct.

Signature	Date

Need help? Call Covered California at 1-800-300-1506 (TTY: 888-889-4500). You can call Monday through Friday, 8:00 A.M. to 5:00 P.M.