SUPPLEMENTAL
MEDI-CAL POTENTIAL OVERPAYMENT REPORTING WORK SHEET
INCOME OR OTHER HEALTH COVERAGE

Section I

County ID

Use this space for additional MFBU members, if needed. Attach to the MC 224 A.

RECIPIENTS INCLUDED IN POTENTIAL OVERPAYMENT (MFBU)

Name	Date of Birth	Social Security Number	Medi-Cal Eligibility Date	
			From	To

Section III—Income Overpayment Computation

Use this space for additional months of overpayment computations, if needed.

1 Month/Year	2 Correct Net Income	3 Correct Maintenance Need	4 Correct Share-of-Cost (2–3)	5 Original Share-of-Cost Met	6 Potential Overpayment (4–5)	7 Amount Paid by Medi-Cal	8 Overpayment (Lower of 6 or 7)
	$	$	$	$	$	$	$

Section IV—County Worker Comments *(If additional space is needed, attach a separate sheet of paper.)*

Section V—County Worker Completing Form

Name (print)	County		
Signature	Date	EW number	Telephone number ( )

White—DHCS Investigations *Yellow—DHCS Investigations* *Pink—County*