Orange County Department of Child Support Services

Steven Eldred, Director

2020 EMPLOYER FORUM

Welcome

- Interactive Webinar
- Adjust your sound/video
- If we get disconnected..
- Questions via chat
- Resources/Recording

AGENDA

- **Opening Remarks**
  - Deputy Director Veronica McNamara
- **Presentation Topics**
  - Child Support Services Overview/Employer Express Team Background
  - Employment Development Department (EDD) – New Hire Registry
  - State Disbursement Unit (SDU)
  - Non IV-D Case
  - Wage and Insurance Verification
  - Income Withholding Order (IWO)
- **Break**
- **Lump Sum IWO**
- **e-IWO**
- **National Medical Support Notice (NMSN)**
- **Website Demonstration**
  - CSS and DCSS Webpage
- **Employer Portal**
- **Q&A**
- **Contact Information**
- **Closing**

Veronica McNamara

Deputy Director, Case Operations
Orange County Department of Child Support Services

David Ruvalcaba
Administrative Manager II
Case Operations

Lynette Favors
Administrative Manager I
Special Collections

Aidee Cooksey
Supervising Child Support Specialist
Employer Express Team

Angela Jones
Employer Outreach Coordinator
California Child Support Services

VM -> LF

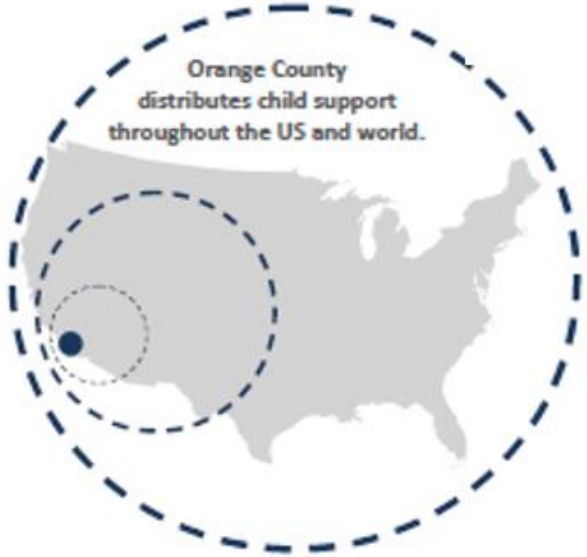
The Child Support Program

Common Child Support Terminology

- A **PPS** is a Parent Ordered to Pay Support. This is most likely your employee.
- A **PRS** is a Person Ordered to Receive Support.
- **Agency/Courts/LCSA** These are entities that work with parents to obtain and enforce court ordered child support orders. A Local Child Support Agency (LCSA) is the Orange County Child Support Agency. That is us.
- **Employer** Person or company providing employment to one of our customers. Employer play a vital role in helping ensure financial security for millions of children through the Income Withholding Orders (IWO) process.

California Child Support Program
Who do we serve?

Over 15.5 Million Children in the US



OC CSS serves over 65,000 families including over 78,000 children, which represents one of every nine children in Orange County

Structure of the Program

OCSE
- Federal Office of Child Support Enforcement

DCSS
- California Child Support Services

LCSA
- 58 Counties with 48 Local Child Support Agencies

Why YOU Matter

- You provide valuable information
- You are our primary partner in the collection of child support payments
- You provide access to health insurance for your employees and their families

Orange County
Child Support Services

CSS Mission

- To facilitate the financial support of children by engaging parents and providing professional child support services.

Vision

- To be a trusted partner of parents in securing financial stability for Orange County's children.

Essential Partners

So far, in FFY 2020 Orange County Child Support Services collected **$114.1 million** through Income Withholding Orders.

That's 64% of our collections!

You contributed to:

Self-sufficient families ● Reduction in poverty levels

Promoting responsibility for both parents

Reporting New Hires

Live Poll

You are required to report Independent Contractors within how many days of hire?

Reporting New Hires

- Any business or public entity that hires new or rehired employees
- Any business or public entity that is required to file a federal form1099-Misc for service performed by an independent contractor

Reporting New Hires

Report employees within 20 days of the first day of work:

- New Hires
- Rehires

Report Independent Contractors within 20 days of contracting:

- Form 1099
- Pay $600 or more

Reporting New Hires

How is new hire reporting information used?

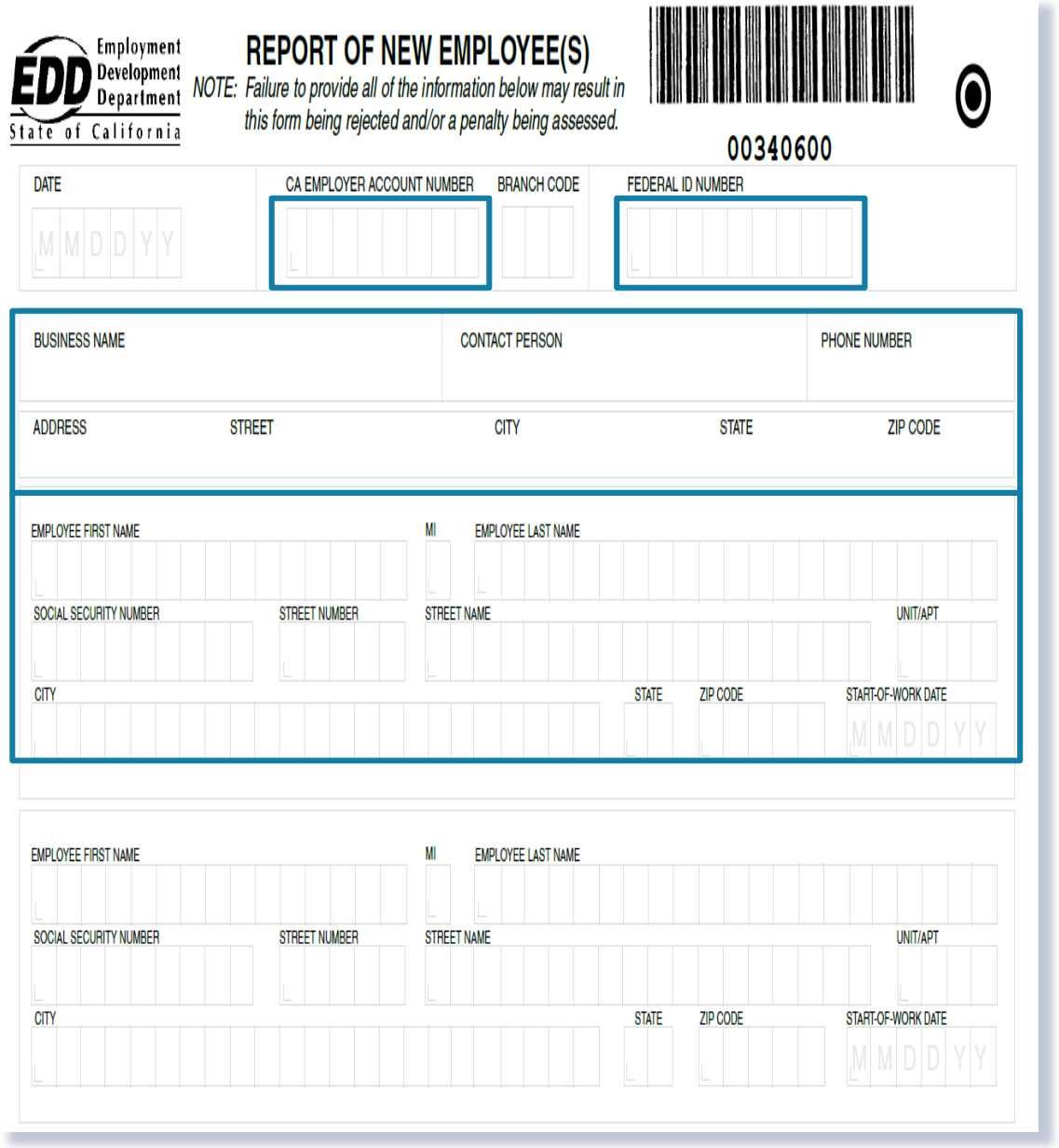
- Reports matched against child support records help:
  - Locate parents
  - Establish orders for support
  - Provide up-to-date earning records

Reporting New Hires

Report your **FEIN, Legal Business Name** and **Business Address** accurately and consistently!

Form DE 34
- Report New Employees

Form DE 542
- Report Independent Contractors



EDD Employment Development Department State of California

REPORT OF NEW EMPLOYEE(S)

NOTE: Failure to provide all of the information below may result in this form being rejected and/or a penalty being assessed.

00340600

DATE (M M D D Y Y) | CA EMPLOYER ACCOUNT NUMBER | BRANCH CODE | FEDERAL ID NUMBER

BUSINESS NAME | CONTACT PERSON | PHONE NUMBER

ADDRESS | STREET | CITY | STATE | ZIP CODE

EMPLOYEE FIRST NAME | MI | EMPLOYEE LAST NAME

SOCIAL SECURITY NUMBER | STREET NUMBER | STREET NAME | UNIT/APT

CITY | STATE | ZIP CODE | START-OF-WORK DATE (M M D D Y Y)

EMPLOYEE FIRST NAME | MI | EMPLOYEE LAST NAME

SOCIAL SECURITY NUMBER | STREET NUMBER | STREET NAME | UNIT/APT

CITY | STATE | ZIP CODE | START-OF-WORK DATE (M M D D Y Y)

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Reporting New Hires

How to Report:

Electronically – Large employers/payroll services – submit bulk uploads

Mail: Employment Development Department
Document Management Group, MIC 96
P.O. Box 997016
West Sacramento, CA 95799-7016

Fax: 916.319.4400

Online: e-Services for Business https://eddservices.edd.ca.gov

For assistance contact EDD: 1-800-796-3524

Reporting New Hires

EDD e-Services for Business:

- Manage your employer payroll tax account
- Register as an employer
- File reports
- Pay deposits and liabilities
- Make address changes

https://eddservices.edd.ca.gov

For tutorials on how to use e-Services for Business, visit
edd.ca.gov/Payroll_Taxes/e-Services_for_Business_Tutorials.htm

New Hire Fact Sheet

New Hire Reporting

California Child Support Services **Fact Sheet**

We're here to help employers report new hires!

Employers reporting newly hired employees help California Child Support Services locate parents, establish Income Withholding Orders (IWOs), and enforce existing IWOs.

New Hires and Rehires are reported to the Employment Development Department (EDD) using form DE 34 and Independent Contractors are reported using form DE 542.

Please report the following information:

Employer's:

- **California Employer Account Number**
- **Branch Code**
- **Federal Employer Identification Number (FEIN)**
- **Legal Business Name and Address**
- **Contact Person Name and Phone Number**

Employee's:

- **Full Name**
- **Social Security Number**
- **Home Address**
- **Start-of-work Date**

New Hires can be reported by fax at (916) 319-4400 or mail at:

Employment Development Department
Document Management Group, MIC 96
P.O. Box 997016
West Sacramento, CA 95799-7016

Or electronically using e-Services for Business

The Employment Development Department (EDD) requires employers to report to California's New Hire Reporting Program.

Report the following employees within 20 days of their start of work date:

⇒ **New Hires**

⇒ **Rehires**

⇒ **Independent Contractors**

Employees rehired after being separated for at least 60 consecutive days, as well as Independent Contractors that are paid $600 or more, or contracted for $600 or more must also be reported to EDD within 20 days.

For additional information visit:
EDD at https://www.edd.ca.gov or contact EDD at (888) 745-3886
e-Services for Business at https://eddservices.edd.ca.gov/

CALIFORNIA
CHILD SUPPORT SERVICES

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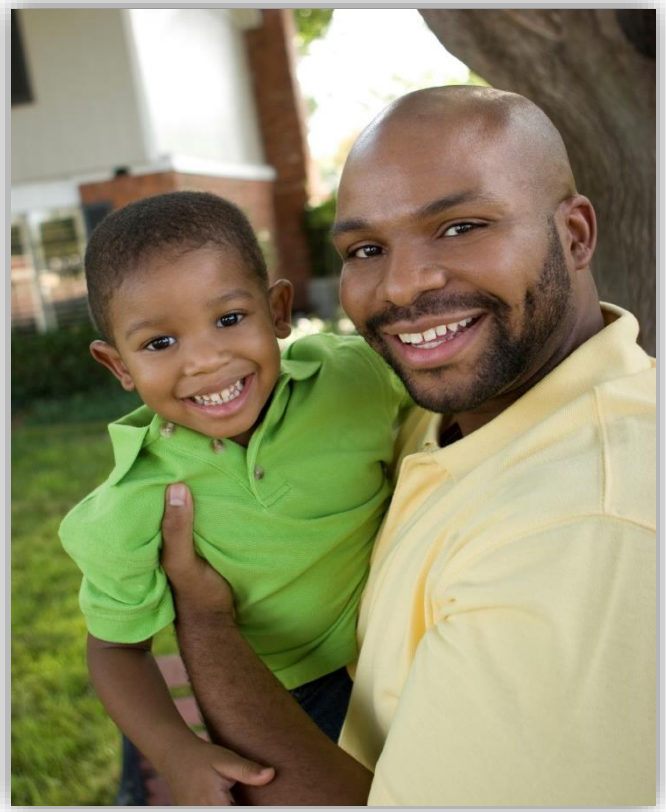
California
State Disbursement Unit (SDU)

Live Poll

How does your company submit child support payments?

Roles and Responsibilities for SDU, State and County

- **SDU**
  - Collection and disbursement processing
  - Electronic help desk
- **DCSS and LCSA**
  - Case management
  - Fund allocation
  - Non IV-D customer service
  - Centralized services – Lump Sum, NSF and Stop Payment



Employer's Responsibilities

- Deduct the appropriate amount per withholding notice
- Remit payment within 7 days of deduction
- Provide identifying information about your employee(s)
- Forward payments to the appropriate state SDU
- Select an Electronic Payment Option

Electronic Payment Options

Pursuant to California Family Code §17309.5, if an employer pays taxes electronically to the Franchise Tax Board (FTB) or the Employment Development Department (EDD), then child support payments are required to be sent to the SDU using Electronic Funds Transfer (EFT).

Electronic Payment Options

- **Automated Clearing House (ACH) Credit**
  - Use your own payroll software to send Automated Clearing House credit payments (similar to direct deposit) utilizing CCD+ or CTX formats using the standard child support addendum segment.
  - The CA SDU electronic help desk is here to help answer any questions by calling (866) 901-3212 (option 1) or email casdu-electronichelpdesk@dcss.ca.gov

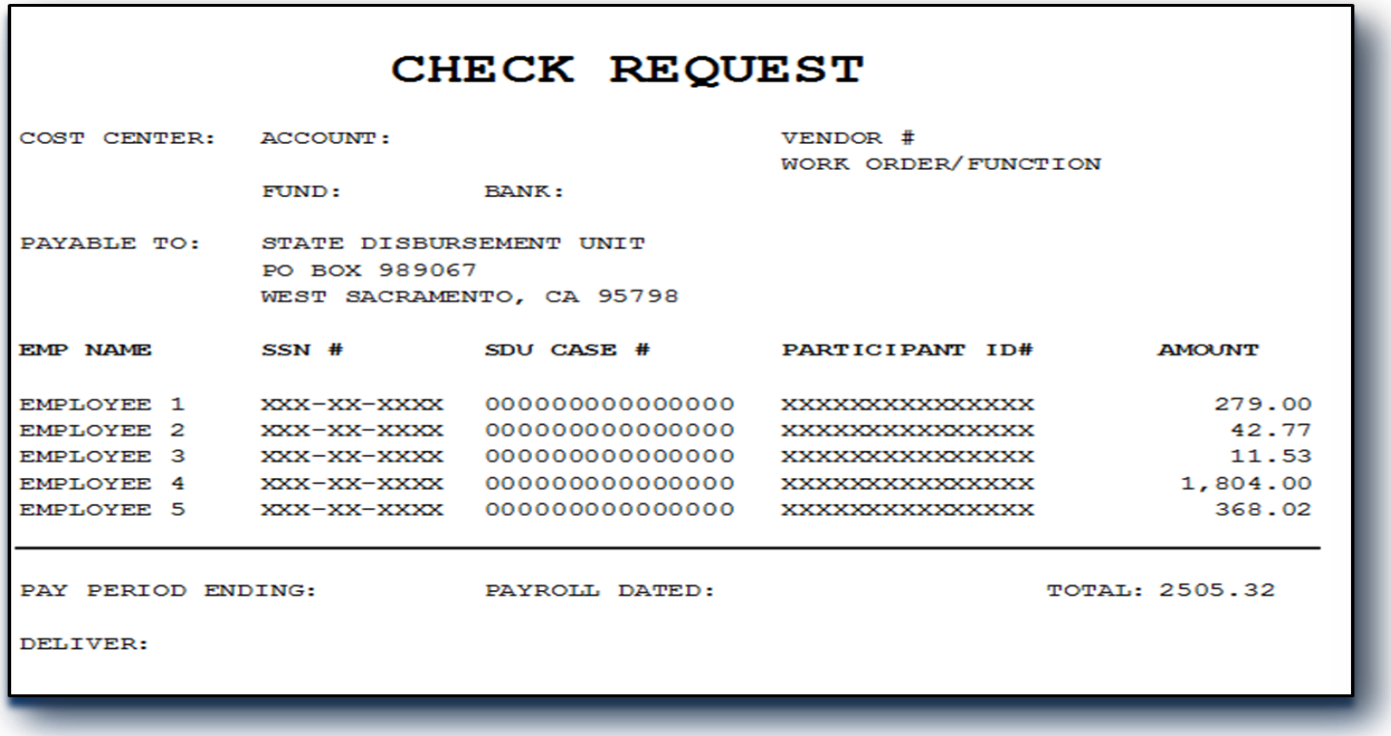
Electronic Payment Options

- **ACH Debit and Credit Card Options**
  - Removal of ACH Debit (Bank Account) option from CA ePortal (formerly CA SDU website)
  - ExpertPay using the ACH Debit and Credit Card option at https://www.ExpertPay.com

Payment Remittance Information

- Employee Name
- Social Security Number
- CSE Participant Identification Number
- Child Support Case Number Provided by the SDU or Other State
- Date of Withholding
- Amount of Payment

Payment Remittance – Insufficient Information



CHECK REQUEST

COST CENTER: ACCOUNT: VENDOR #
WORK ORDER/FUNCTION
FUND: BANK:

PAYABLE TO: STATE DISBURSEMENT UNIT
PO BOX 989067
WEST SACRAMENTO, CA 95798

EMP NAME	SSN #	SDU CASE #	PARTICIPANT ID#	AMOUNT
EMPLOYEE 1	XXX-XX-XXXX	0000000000000000	XXXXXXXXXXXXXXX	279.00
EMPLOYEE 2	XXX-XX-XXXX	0000000000000000	XXXXXXXXXXXXXXX	42.77
EMPLOYEE 3	XXX-XX-XXXX	0000000000000000	XXXXXXXXXXXXXXX	11.53
EMPLOYEE 4	XXX-XX-XXXX	0000000000000000	XXXXXXXXXXXXXXX	1,804.00
EMPLOYEE 5	XXX-XX-XXXX	0000000000000000	XXXXXXXXXXXXXXX	368.02

PAY PERIOD ENDING: PAYROLL DATED: TOTAL: 2505.32

DELIVER:

Payments that do not have the appropriate remittance information is at higher risk of the payments getting suspended.

Have questions on what identifiers need to be remitted?

Please email casdu-electronichelpdesk@dcss.ca.gov

Payment Options

Remitting Checks for Out-Of-State Employers

State Disbursement Unit

P.O. BOX 989067

West Sacramento, CA 95798-9067

(866)901-3212 (Option 1)

Payments should never be mailed directly to the local child support agency issuing the IWO

NON IV-D

Live Poll

Non IV-D payments can be sent directly to the Custodial Party.

What is Non IV-D?

- Person Ordered to Receive Support has not requested assistance from the local child support agency
- Child Support Order enforced by Person Ordered to Receive Support
- Income Withholding Order (IWO) /National Medical Support Notice (NMSN) and underlying order are filed and served by Person Ordered to Receive Support/Attorney
- Person Ordered to Receive Support/Attorney is responsible for amending updating or terminating the IWO/NMSN

Employer's Responsibilities

IWOs dated prior to **May 31, 2011**

- If the IWO is not payable through the SDU, request a new IWO payable through the SDU.
- If the IWO was issued on the outdated form, return the original IWO to the sender and request a new IWO on the correct federal form.
  - **FL-195**
  - **OMB0970-0154**

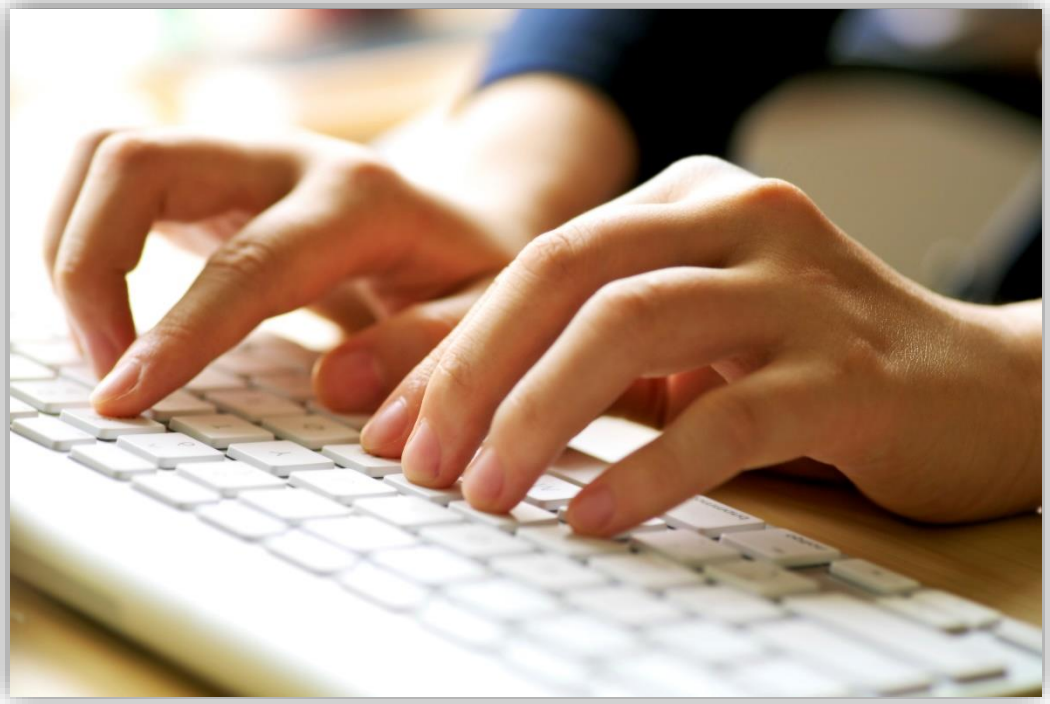
Employer's Responsibilities

- Send all earnings withheld to the SDU regardless of who issued the IWO (CA Code 5235e)
- Register ALL Non IV-D/Private Cases with the SDU before making the payment
- Contact our office should you receive an IWO from the LCSA when there is already a Non IV-D/Private Case

Local Child Support Agency Limitations

- Local child support agency is able to determine if a Non IV-D case exists
- Local child support agency does not have the ability to modify or terminate an IWO issued by the Person Ordered to Receive Support/ Attorney
- For questions or concerns regarding a Non IV-D/Private Case you must contact the issuing party or call the SDU at (866) 901-3212 (Option 1)

Wage and Insurance Verifications



Wage and Insurance Verification Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

WAGE AND INSURANCE VERIFICATION

DCSS 0230 (01/18/15)

CSE Case Number: 24681012
Participant Name: TOM MICE
EMPLOYER NAME: LOONEY TOONEY LLC

EMPLOYEE/CASE PARTICIPANT IDENTIFICATION AND CONTACT INFORMATION *(If you have different information, write new information in the blank spaces.)*

A. Name: TOM MICE
B. Social Security Number: 222-22-2222
C. Date of Birth: 02/14/1981
D. Address: 1055 N. MAIN ST. SANTA ANA, CA 92701
E. Phone Number: 866-901-3212

EMPLOYEE WORK STATUS *(Check all applicable boxes and fill in requested information.)*

☐ Never employed *(If never employed, no need to complete form further. Just sign the certification on page 3 and return entire form.)*

☐ Currently employed: ☐ Part-time ☐ Full-time ☐ Seasonal

Usual season start date: _____ Usual season end date: _____

☐ No longer employed: Last date employed: _____

Reason for termination of employment: _____

New employer name and address: _____

_____

Is there an Income Withholding Order for support on file in your business for this employee? ☐ Yes ☐ No

What income tax filing status does employee report? ☐ Single ☐ Head of Household ☐ Married

How many dependents does employee claim for income tax withholding purposes? _____

Employee Earnings Section

EMPLOYEE EARNINGS

Next Pay Date *(Month, Day, Year)*

Pay Frequency *(Check one)* ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

Hourly Rate *(If applicable)* $ _____ Number of Hours _____

Monthly Deduction *For Mandatory Retirement* $ _____ *For Mandatory Union Dues* $ _____

Union Name | Union Local Number

Period of Employment *From (Month, Day, Year)* *To (Month, Day, Year)*

Please complete employee's earnings for the past 12 months or attach a copy of payroll earnings for those months. If the worked less than 12 months, provide the information for the number of months employee did have earnings.

☐ Check if copy of payroll earnings is attached. ☐ Check if employee has worked less than 12 months.

Attach copy of payroll earnings

Month / Year	Gross	Month / Year	Gross	Month / Year	Gross
January	$	July	$	January	$
February	$	August	$	February	$
March	$	September	$	March	$
April	$	October	$	April	$
May	$	November	$	May	$
June	$	December	$	June	$

Health Insurance Information Section

Provide coverage information for dependent(s) already covered

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

WAGE AND INSURANCE VERIFICATION

DCSS 0230 (01/18/15)

CSE Case Number: 24681012
Participant Name: TOM MICE
EMPLOYER NAME: LOONEY TOONEY LLC

HEALTH INSURANCE INFORMATION *(**Note to the preparer:** If more than one plan is available to the employee, **please list the lowest cost insurance plan** available for the employee, even if it is different than the plan the employee is presently enrolled in.)*

Check all applicable boxes:

☐ No health insurance is available to: ☐ Employee ☐ Employee's dependents

☐ Health insurance is available at **no cost** for: ☐ Employee ☐ Employee's dependents

☐ Cost to the employee of ***lowest cost*** available health insurance **for employee only**:

Cost reported is for period: ☐ Annual ☐ Monthly ☐ Two Weeks ☐ Weekly ☐ Other

☐ Medical: $_____ ☐ Dental: $_____ ☐ Vision: $_____ ☐ Other: $_____

☐ Cost to the employee of ***lowest cost*** available health insurance **for each of employee's insured dependents**:

Cost reported is for period: ☐ Annual ☐ Monthly ☐ Two Weeks ☐ Weekly ☐ Other

☐ Medical: $_____ ☐ Dental: $_____ ☐ Vision: $_____ ☐ Other: $_____

☐ **Total** cost to the employee of ***lowest cost*** available health insurance **for employee and all of employee's insured dependents**:

Cost reported is for period: ☐ Annual ☐ Monthly ☐ Two Weeks ☐ Weekly ☐ Other

☐ Medical: $_____ ☐ Dental: $_____ ☐ Vision: $_____ ☐ Other: $_____

DEPENDENT INFORMATION *(List names of all of employee's insured dependents. Add a sheet of paper if more space needed.)*

POLICY INFORMATION

	MEDICAL	DENTAL	VISION	OTHER

Certification of Record Section

CERTIFICATION OF RECORD

I have personally completed this form, or printed and attached records containing **all** of the employee's earnings and benefits information requested in this form, from the payroll records in my custody and control. I am personally aware such records are kept in the regular course of business and that entries therein are made at or about the time of the condition or event. I have compared the records with the above Wage and Insurance Verification (DCSS 0230) and know the information I am supplying to be accurate.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Print Name	Signature	Executed on *(Date)*
Job Title	Address	
Name of Company or Business Organization		

Your contact information

Telephone Number	Fax Number	Email Address

Income Withholding Order Notice for Support

Income Withholding Order

The order or notice issued by a court or administrative child support agency and served on an employer whose employee has a support obligation:

- Takes effect immediately and remains in effect until further notice
- California Code directs employers to keep an IWO on file for one year after separation of employment

Obligations of LCSA

- Obtained in every case with a support order
- Served on Employer within **15 days** from entry of support order **or** when new employer information is obtained

Employer's Responsibilities

- Within 10 days of receiving IWO form the employer must notify the employee named and provide him/her with a copy of the Order/Notice, and a blank Request for Hearing Regarding Earnings Assignment with information and instruction sheet
- Begin withholding the amount specified in the order no later than the first pay period occurring 10 days after receipt of the IWO
- Remit the payment to SDU within 7 working days of the pay date/date of withholding until served a notice modifying amount to be withheld or terminating the order.

Employer's Responsibilities

When the employee terminates, inform LCSA on or before the next payment due date of:

- Date of termination
- New employer's name and address (if known)
- Employee's last known address and telephone number

Employers cannot do the following based on the existence of an IWO:

- Refuse to hire
- Discriminate
- Discipline
- Terminate

Live Poll

The person on the IWO is not my employee, they are an Independent Contractor (I issue a 1099) so…I don't have to honor the withholding.

Penalties for Employers

An employer who willfully fails to withhold and forward support is liable for the amount of support not withheld, forwarded or paid, including interest.

Family Code Section 5241 - Civil penalties can be up to 50% of the support amount

Impact to your Employee

Credit for payment is given on the day it is received at the SDU.

Missed payments can result in:

- Negative credit reporting
- 10% interest charge per year
- State license suspension
- Bank levies
- Passport denial

Confidentiality

- LCSA case records are CONFIDENTIAL
- LCSA can only discuss the case as it relates to the employer's ability and/or obligation to process the IWO

If your employees have questions regarding their child support amount, encourage them to contact the LCSA directly. There are programs available to assist them:

- Administrative Wage Assignment Review
- COAP – Compromise of Arrears Program
- SLMS – Driver License issues
- Review and Adjustment of current child support obligation

IWO Packet-Cover Page

- You will receive an IWO in the form of a multi-page packet.
- Subject: What you are receiving
- Employee/Case Information
- Instructions and legal requirements employers must follow
- Contact and website information

IWO Fact Sheet

Income Withholding Order

California Child Support Services **Fact Sheet**

Employer Guide for Processing Income Withholding Orders

Employers are a valuable partner in California's child support program. Your efforts amount to 70 percent of child support payments for children and families.

As the employer, begin to withhold child support and or medical support no later than the first pay period after receiving the Income Withholding Order (IWO).

Provide the employee with the following within 10 calendar days:

1. **Copy of the IWO**
2. **Copy of the Statement of Employee's Rights**
3. **Instructions to file for relief**

All payments are forwarded to the California State Disbursement Unit (SDU) within 7 business days of the employee pay date. Per California Family Code Section 17309.5, California employers are required to send child support payments electronically to the SDU. There are several electronic payment options available:

- **www.casdu.com**
- **https://www.expertpay.com**
- **casdu-electronichelpdesk@dcss.ca.gov**
- **By Phone at (866) 901-3212 option 1**

Out-of-state employers may send checks to:
California State Disbursement Unit
P.O. Box 989067
West Sacramento, CA 95798-9067

Notify the child support agency at (866) 901-3212 if your employee is terminated, changes employers, or there is a stop in the withholding of child support or medical support.

The Income Withholding Order (IWO) is a court order that is provided to the employer.

Each IWO directs the employer to withhold from your employee's paycheck for child support and medical support. Employers may receive an IWO from either:

⇒ **Child Support Agency**

⇒ **Out of State Child Support Agency**

⇒ **Private Party**

For additional information visit:
Employer Resource Center at: https://childsupport.ca.gov/employer-resource-center/employer-faqs/
or the Employer Handbook at: https://childsupport.ca.gov/employer-resource-center/

CALIFORNIA
CHILD SUPPORT SERVICES

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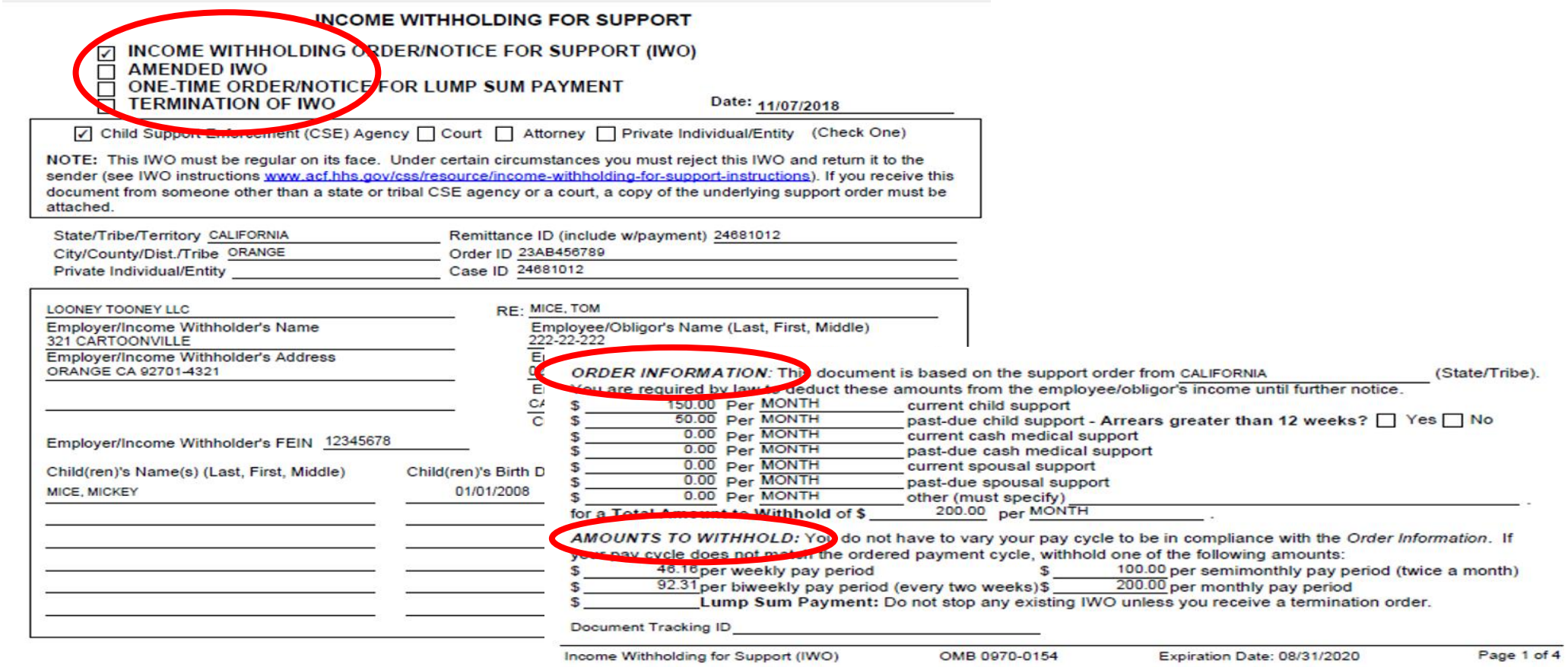
Order Information to Withhold (Page 1)



INCOME WITHHOLDING FOR SUPPORT

☑ INCOME WITHHOLDING ORDER/NOTICE FOR SUPPORT (IWO)
☐ AMENDED IWO
☐ ONE-TIME ORDER/NOTICE FOR LUMP SUM PAYMENT
☐ TERMINATION OF IWO

Date: 11/07/2018

☑ Child Support Enforcement (CSE) Agency ☐ Court ☐ Attorney ☐ Private Individual/Entity (Check One)

NOTE: This IWO must be regular on its face. Under certain circumstances you must reject this IWO and return it to the sender (see IWO instructions www.acf.hhs.gov/css/resource/income-withholding-for-support-instructions). If you receive this document from someone other than a state or tribal CSE agency or a court, a copy of the underlying support order must be attached.

State/Tribe/Territory CALIFORNIA
City/County/Dist./Tribe ORANGE
Private Individual/Entity

Remittance ID (include w/payment) 24681012
Order ID 23AB456789
Case ID 24681012

LOONEY TOONEY LLC
Employer/Income Withholder's Name
321 CARTOONVILLE
Employer/Income Withholder's Address
ORANGE CA 92701-4321

Employer/Income Withholder's FEIN 12345678

RE: MICE, TOM
Employee/Obligor's Name (Last, First, Middle)
222-22-222

Child(ren)'s Name(s) (Last, First, Middle) | Child(ren)'s Birth D
MICE, MICKEY | 01/01/2008

ORDER INFORMATION: This document is based on the support order from CALIFORNIA (State/Tribe).
You are required by law to deduct these amounts from the employee/obligor's income until further notice.

$ 150.00	Per MONTH		current child support
$ 50.00	Per MONTH		past-due child support - **Arrears greater than 12 weeks?** ☐ Yes ☐ No
$ 0.00	Per MONTH		current cash medical support
$ 0.00	Per MONTH		past-due cash medical support
$ 0.00	Per MONTH		current spousal support
$ 0.00	Per MONTH		past-due spousal support
$ 0.00	Per MONTH		other (must specify)

for a Total Amount to Withhold of $ 200.00 per MONTH .

AMOUNTS TO WITHHOLD: You do not have to vary your pay cycle to be in compliance with the *Order Information*. If your pay cycle does not match the ordered payment cycle, withhold one of the following amounts:

$ 46.16	per weekly pay period	$ 100.00	per semimonthly pay period (twice a month)
$ 92.31	per biweekly pay period (every two weeks)	$ 200.00	per monthly pay period
$	**Lump Sum Payment:** Do not stop any existing IWO unless you receive a termination order.		

Document Tracking ID

Income Withholding for Support (IWO) OMB 0970-0154 Expiration Date: 08/31/2020 Page 1 of 4

Remittance information (Page 2)

Employer's Name: LOONEY TOONEY LLC Employer FEIN: 12345678

Employee/Obligor's Name: MICE, TOM SSN: 222-22-222

Case Identifier: 24001012 Order Identifier: 23AB456789

REMITTANCE INFORMATION: If the employee/obligor's principal place of employment is CALIFORNIA (State/Tribe), you must begin withholding no later than the first pay period that occurs 10 days after the date of 11/07/2018. Send payment within 7 business days of the pay date. If you cannot withhold the full amount of support for any or all orders for this employee/obligor, withhold 50 % of disposable income for all orders. If the obligor is a non-employee, obtain withholding limits from Supplemental Information. If the employee/obligor's principal place of employment is not CALIFORNIA (State/Tribe), obtain withholding limitations, time requirements, and any allowable employer fees from the jurisdiction of the employee/obligor's principal place of employment. State-specfic withholding limit information is available at www.acf.hhs.gov/css/resource/state-income-withholding-contacts-and-program-requirements. For tribe-specific contacts, payment addresses, and withholding limitations, please contact the tribe at www.acf.hhs.gov/sites/default/files/programs/css/tribal_agency_contacts_printable_pdf.pdf or https://www.bia.gov/tribalmap/DataDotGovSamples/tld_map.html.

For electronic payment requirements and centralized payment collection and disbursement facility information [State Disbursement Unit (SDU)], see www.acf.hhs.gov/css/employers/employer-responsibilities/payments.

Include the Remittance ID with the payment and if necessary this locator code: 0600099.

Remit payment to CALIFORNIA STATE DISBURSEMENT UNIT (SDU/Tribal Order Payee)
at PO BOX 989067 WEST SACRAMENTO CA 9578-9067 (SDU/Tribal Payee Address)

Live Poll

As an employer I am responsible for informing the LCSA of the employee's…

Employee status (Page 4)

Employer's Name: LOONEY TOONEY LLC Employer FEIN: 12345678

Employee/Obligor's Name: MICE, TOM SSN: 222-22-222

Case Identifier: [illegible] Order Identifier: 23AB456789

NOTIFICATION OF EMPLOYMENT TERMINATION OR INCOME STATUS: If this employee/obligor never worked for you or you are no longer withholding income for this employee/obligor, you must promptly notify the CSE agency and/or the sender by returning this form to the address listed in the contact information below:

☐ This person has never worked for this employer nor received periodic income.

☐ This person no longer works for this employer nor receives periodic income.

Please provide the following information for the employee/obligor:

Termination date: _____ Last known telephone number: _____

Last known address: _____

_____

Final payment date to SDU/Tribal Payee: _____ Final payment amount: _____

New employer's name: _____

New employer's address: _____

_____

CONTACT INFORMATION:

To Employer/Income Withholder: If you have questions, contact California Department of Child Support Services (issuer name)

by telephone: (866)901-3212, by fax: (714)347-4811, by email or website: childsupport@css.ocgov.com.

Send termination/income status notice and other correspondence to:

_____ (issuer address).

To Employee/Obligor: If the employee/obligor has questions, contact _____ (issuer name)

by telephone: _____, by fax: _____, by email or website: _____.

IMPORTANT: The person completing this form is advised that the information may be shared with the employee/obligor.

Encryption Requirements:
When communicating this form through electronic transmission, precautions must be taken to ensure the security of the

Complete & return to us

What are Earnings?

Family Code Section 5206 defines earnings as:

- Wages
- Vacation Pay
- Dividends
- Salary
- Retirement
- Royalties
- Bonuses
- Commissions
- Residuals
- Payments for independent contractor services

The enforcement action is authorized under FC section 5246

Priority of Multiple IWOs

1. Child Support Order
2. Bankruptcy order
3. Federal Administrative Garnishment
4. Federal Tax Levy*
5. Student Loan
6. State Tax Levy
7. Local Tax Levy
8. Creditor Garnishment
9. Employer Deductions

If you received multiple Orders and you're not sure which one has priority, call us.

**Levy received prior to Child Support order has priority*

Priority of Deductions for an IWO

1. Current Child/ Family Support
2. Medical Support (if on IWO)
3. Current Spousal Support
4. Health Insurance Premium
5. Child/Family Support Arrears
6. Spousal Support Arrears

Current Child Support always takes priority over other deductions (with possible exception of IRS tax liens).

Live Poll

What is the withholding limit in the state of California?

Calculating Net Disposable Income (NDI) and Maximum Support Deduction (MSD)

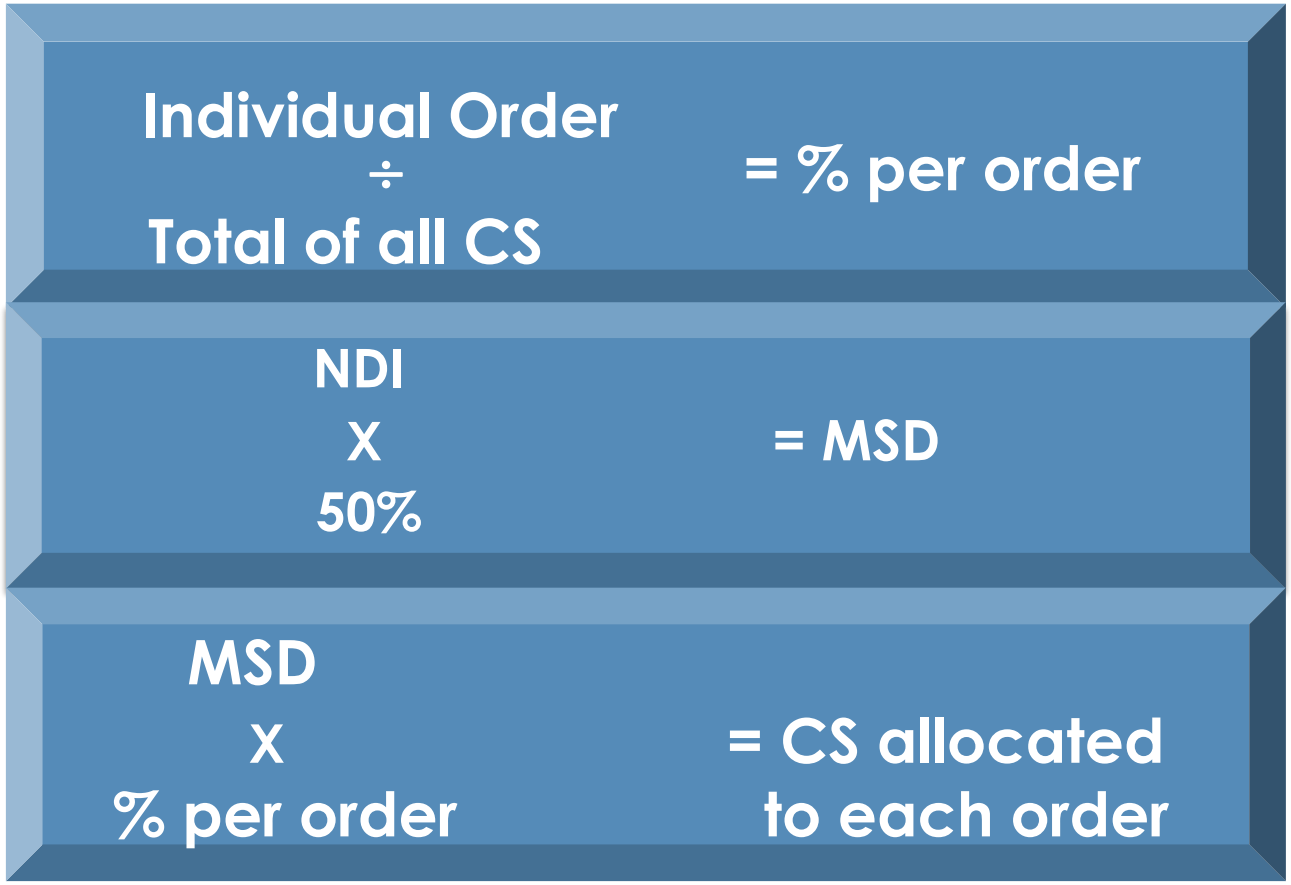
NDI=Gross earnings minus ONLY:

Mandatory deductions

- State and federal taxes
- SDI
- Union dues
- Retirement (not 401k)

MSD=NDI x 50%

Child Support Allocation for Multiple Orders



Multiple Orders Less than MSD

Net Disposable Income	**$662**
	x 50%
Maximum Support Deduction	**$331**

Order	C/S	Arrears	Total
A	$150 +	$ 50 =	$200
B	$100 +	$ 25 =	$125
Combined Total			$325

Multiple Orders Exceed MSD

Net Disposable Income	**$662**
	x 50%
Maximum Support Deduction	**$331**

Order	C/S	Arrears	Total
A	$150 +	$ 50 =	$200
B	$100 +	$ 25 =	$125
C	$175 +	$ 25 =	$200
Combined Total	$425 +	$100 =	$525

Multiple Orders Exceed MSD (Cont'd)

Order	C/S	Total C/S	% to Withhold
A	$150 ÷	$425 =	35%
B	$100 ÷	$425 =	24%
C	$175 ÷	$425 =	41%
Total	$425		100%

MSD
$331

Order	MSD	% to Withhold	Allocate
A	$331 x	35% =	$115.85
B	$331 x	24% =	$ 79.44
C	$331 x	41% =	$135.71
		100% =	$331

Live Poll

On an NDI of $1,400 the MSD is…

IWO Exercise
Tipped Employees

Scenario:

- Employee is a server at your restaurant and receives an hourly minimum wage + tips
- Tips are paid in CASH directly to employee, who then reports the amount to you
- You (employer) deduct taxes on the total from Salary AND Tips, then pay employee any remaining amount (sometimes it can be zero)

Current Support Obligation: $300

Employee earns $100 (after taxes) plus $200 in tips

How would you garnish?

How would you garnish?

- Combine the wages and tips ($100 + $200)

  $300 total earnings

- Calculate 50% of $300 to determine MSD

  MSD = $150

Answer:

Since the employee already received $200 in tips, you would garnish the full paycheck of $100


Break

Lump Sum Income Withholding Order

Live Poll

Should I notify the local child support agency if I have an employee who will be receiving bonus pay or a settlement?

Lump Sum IWO

These payments include:

- Bonus pay/Commissions
- Severance or buy out payments
- Vacation payouts
- Retirement incentives
- Commissions

Lump Sum IWO

FL-195

INCOME WITHHOLDING FOR SUPPORT

- ☐ INCOME WITHHOLDING ORDER/NOTICE FOR SUPPORT (IWO)
- ☐ AMENDED IWO
- ☑ ONE-TIME ORDER/NOTICE FOR LUMP SUM PAYMENT
- ☐ TERMINATION OF IWO

Date:

☑ Child Support Enforcement (CSE) Agency ☐ Court ☐ Attorney ☐ Private Individual/Entity (Check One)

NOTE: This IWO must be regular on its face. Under certain circumstances you must reject this IWO and return it to the sender (see IWO instructions www.acf.hhs.gov/css/resource/income-withholding-for-support-instructions). If you receive this document from someone other than a state or tribal CSE agency or a court, a copy of the underlying support order must be attached.

State/Tribe/Territory
City/County/Dist./Tribe
Private Individual/Entity
Remittance ID (include w/payment)
Order ID
Case ID

Employer/Income Withholder's Name
Employer/Income Withholder's Address
Employer/Income Withholder's FEIN

RE:
Employee/Obligor's Name (Last, First, Middle)
Employee/Obligor's Social Security Number
Employee/Obligor's Date of Birth
Custodial Party/Obligee's Name (Last, First, Middle)

Child(ren)'s Name(s) (Last, First, Middle)
Child(ren)'s Birth Date(s)

ORDER INFORMATION: This document is based on the support order from (State/Tribe).
You are required by law to deduct these amounts from the employee/obligor's income until further notice.

$ Per current child support
$ Per past-due child support - **Arrears greater than 12 weeks?** ☐ Yes ☐ No
$ Per current cash medical support
$ Per past-due cash medical support
$ Per current spousal support
$ Per past-due spousal support
$ Per other (must specify) .

for a **Total Amount to Withhold** of **$** per .

AMOUNTS TO WITHHOLD: You do not have to vary your pay cycle to be in compliance with the *Order Information*. If your pay cycle does not match the ordered payment cycle, withhold one of the following amounts:

$ per weekly pay period
$ per semimonthly pay period (twice a month)
$ per biweekly pay period (every two weeks)
$ per monthly pay period
$ **Lump Sum Payment:** Do not stop any existing IWO unless you receive a termination order.

Document Tracking ID

AJ

How to Report Bonus/Lump Sum Payments

Child Support Portal
https://www.acf.hhs.gov/css/resource/report-lump-sum-payments-online#signup

lumpsumresponseteam@dcss.ca.gov

(916) 464-6640

Report bonus or lump sum payments prior to payout

Electronic Income Withholding Order (e-IWO)

Live Poll

Paper mail is the only way to receive the IWO?

e-IWO

- **What is e-IWO?**
  - Receive Income Withholding Orders (IWO) electronically
  - Notify child support agencies of terminations and lump sums
  - Acknowledge acceptance or rejection of IWOs

"A paperless solution"

e-IWO Benefits

- Secure electronic process for managing IWO
- Employers save time, money and resources
- Ensures uniform IWO data from all states
- Increases accuracy and reliability of data
- Families receive payments faster

e-IWO

- **Two options to implement:**
  - System-to-System interface (High volume IWO)
    - ✓ Requires IT resources for programing
  - No Programming option (Low volume IWO)
    - ✓ PDF copy of IWO is provided
    - ✓ Easy to Implement
    - ✓ Minimal IT investment
    - ✓ Ability to accept or reject IWOs
    - ✓ Handles terminations and lump sum reporting

Registration for e-IWO

Complete a **profile form** and **FEIN spreadsheet**

The Registration includes an agreement to process e-IWOs.

Department of Health and Human Services
Administration for Families and Children
Office of Child Support Enforcement

Agreement to Receive Electronic Income Withholding Orders/Notices

By completing and providing the information contained in the e-IWO Employer/Payroll Provider Profile Form, the employer, company or government agency agrees that it will:

Electronically receive income withholding orders/notices issued by a state, tribe or territory.

Not impersonate any individual, entity or association, use false headers or otherwise conceal or provide misleading information about my identity while receiving income withholding orders/notices electronically.

Provide true, accurate, current and complete information about the entity identified in the profile form.

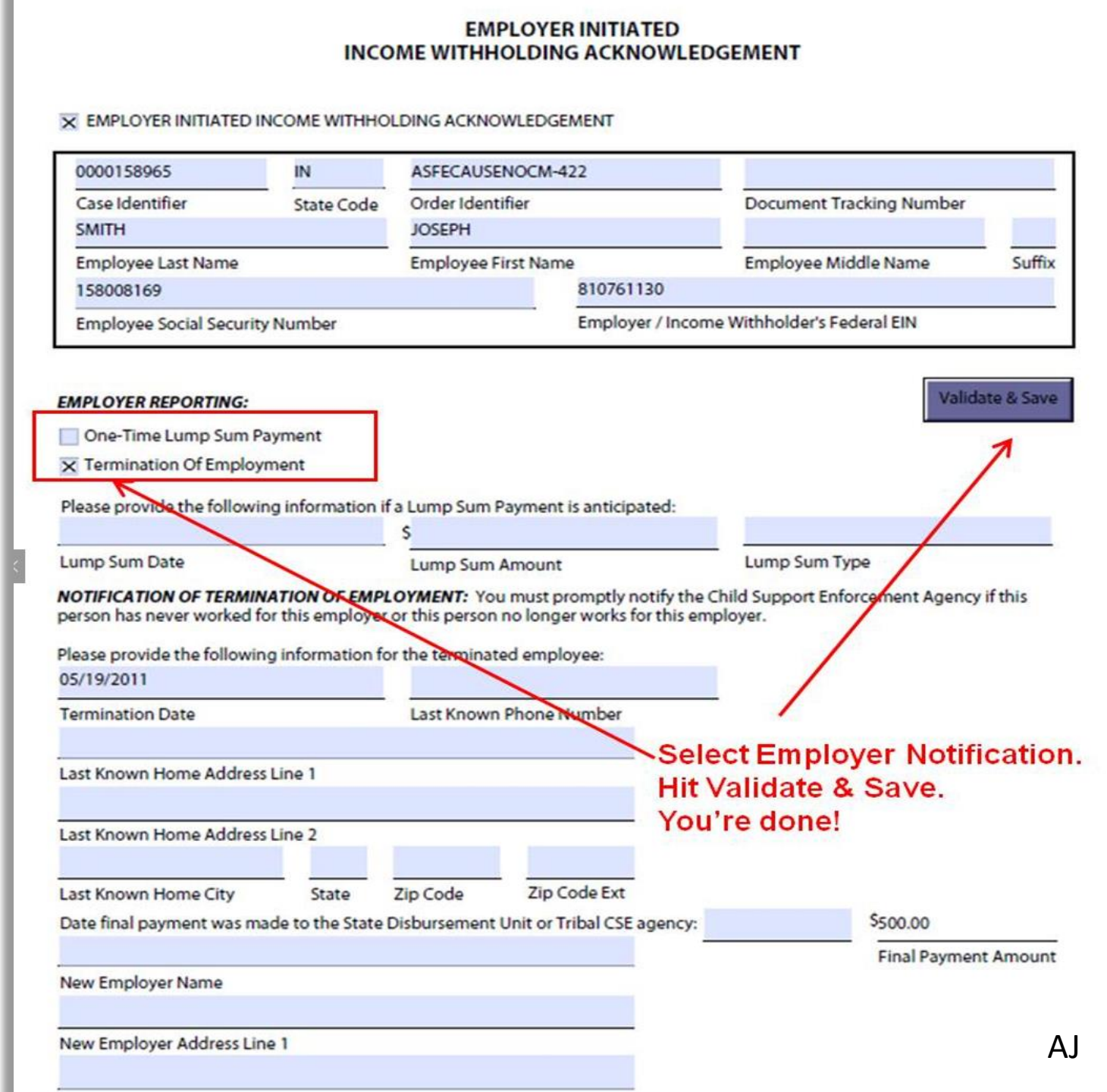
Receive, handle and process income withholding orders/notices electronically transmitted in the same manner as if they were received via regular mail; and that any electronic income withholding orders it receives shall be considered records generated during the ordinary course of business; and the electronic income withholding orders received by it shall be considered admissible as evidence in the same manner as paper documents.

Provide written notice to the federal Office of Child Support Enforcement, at least 30 days in advance, of its intent to no longer accept electronic income withholding orders.

AJ

Notify the child support agency of an **employment event change**

- Termination
- Lump sum
- Change in employment status



EMPLOYER INITIATED
INCOME WITHHOLDING ACKNOWLEDGEMENT

☒ EMPLOYER INITIATED INCOME WITHHOLDING ACKNOWLEDGEMENT

0000158965	IN	ASFECAUSENOCM-422	
Case Identifier	State Code	Order Identifier	Document Tracking Number
SMITH	JOSEPH		
Employee Last Name	Employee First Name	Employee Middle Name	Suffix
158008169	810761130		
Employee Social Security Number	Employer / Income Withholder's Federal EIN		

Validate & Save

EMPLOYER REPORTING:

☐ One-Time Lump Sum Payment
☒ Termination Of Employment

Please provide the following information if a Lump Sum Payment is anticipated:

Lump Sum Date | $ Lump Sum Amount | Lump Sum Type

NOTIFICATION OF TERMINATION OF EMPLOYMENT: You must promptly notify the Child Support Enforcement Agency if this person has never worked for this employer or this person no longer works for this employer.

Please provide the following information for the terminated employee:

05/19/2011
Termination Date | Last Known Phone Number

Last Known Home Address Line 1

Last Known Home Address Line 2

Last Known Home City | State | Zip Code | Zip Code Ext

Date final payment was made to the State Disbursement Unit or Tribal CSE agency:

$500.00
Final Payment Amount

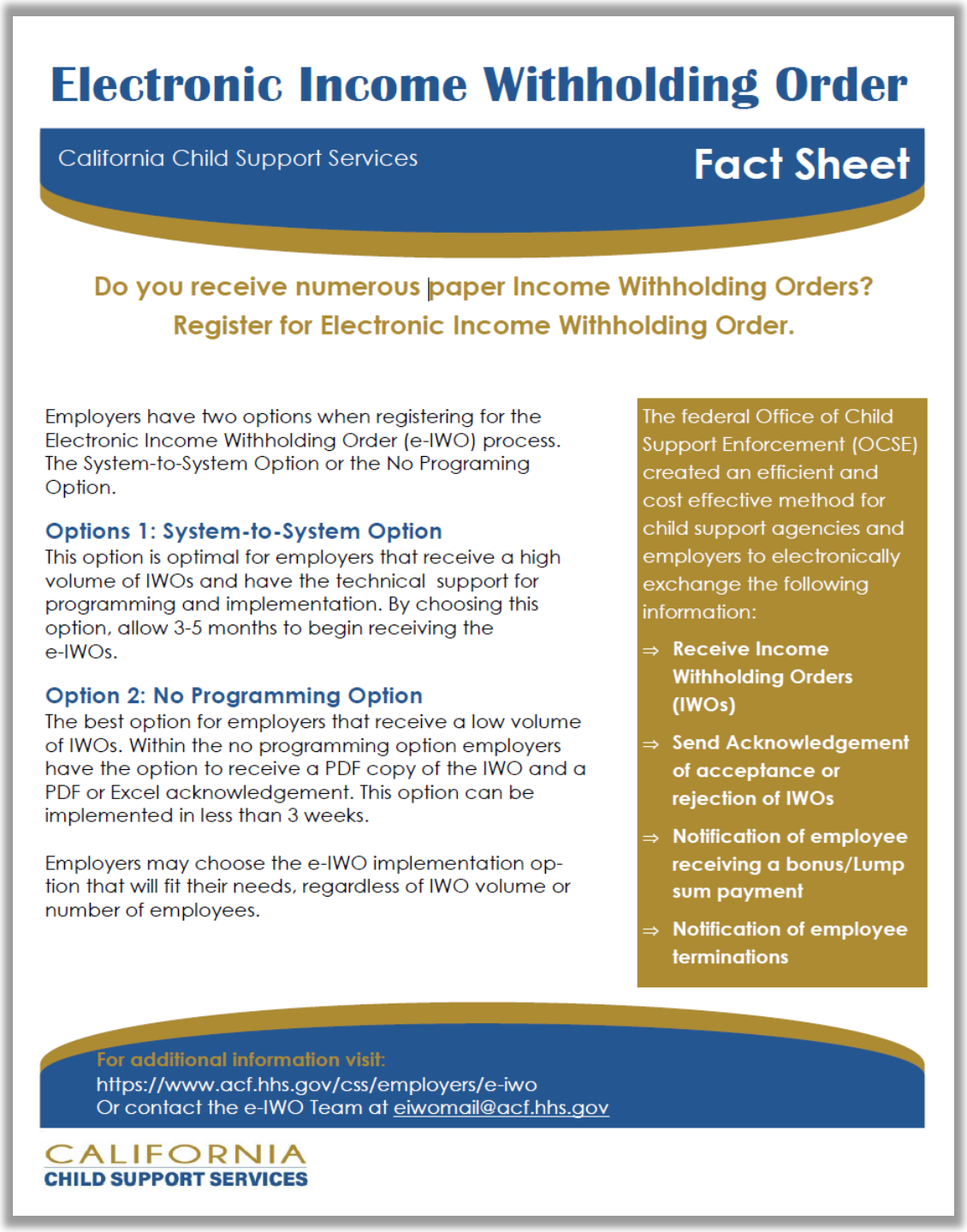
New Employer Name

New Employer Address Line 1

Select Employer Notification.
Hit Validate & Save.
You're done!

AJ

e-IWO Fact Sheet



Electronic Income Withholding Order

California Child Support Services

Fact Sheet

Do you receive numerous paper Income Withholding Orders?
Register for Electronic Income Withholding Order.

Employers have two options when registering for the Electronic Income Withholding Order (e-IWO) process. The System-to-System Option or the No Programing Option.

Options 1: System-to-System Option

This option is optimal for employers that receive a high volume of IWOs and have the technical support for programming and implementation. By choosing this option, allow 3-5 months to begin receiving the e-IWOs.

Option 2: No Programming Option

The best option for employers that receive a low volume of IWOs. Within the no programming option employers have the option to receive a PDF copy of the IWO and a PDF or Excel acknowledgement. This option can be implemented in less than 3 weeks.

Employers may choose the e-IWO implementation option that will fit their needs, regardless of IWO volume or number of employees.

The federal Office of Child Support Enforcement (OCSE) created an efficient and cost effective method for child support agencies and employers to electronically exchange the following information:

- ⇒ **Receive Income Withholding Orders (IWOs)**
- ⇒ **Send Acknowledgement of acceptance or rejection of IWOs**
- ⇒ **Notification of employee receiving a bonus/Lump sum payment**
- ⇒ **Notification of employee terminations**

For additional information visit:
https://www.acf.hhs.gov/css/employers/e-iwo
Or contact the e-IWO Team at eiwomail@acf.hhs.gov

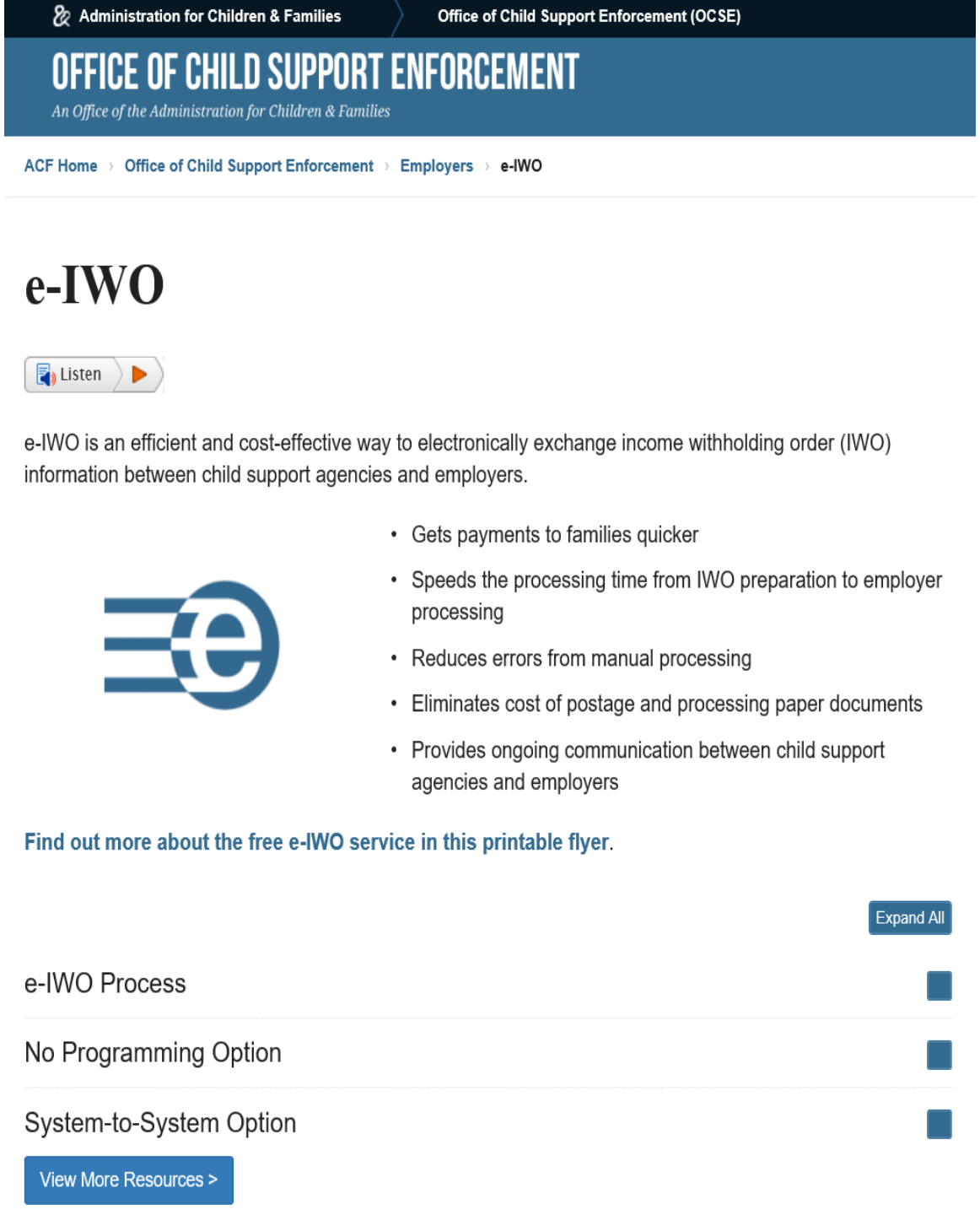
CALIFORNIA
CHILD SUPPORT SERVICES

AJ

e-IWO Resources

To get started, contact : eiwomail@acf.hhs.gov

Visit: http://www.acf.hhs.gov/programs/css/employers/e-iwo



AJ -> DR

National Medical Support Notice (NMSN)

LCSA Responsibility

- By law, every order for child support must include a health insurance provision
- Obtain and enforce orders for health insurance coverage
- Serve the order on the employer
- Provide PRS with health insurance information for the child
- Health insurance must be provided to the employee's children even if the employee declines his/her own personal coverage

Employer's Responsibilities

Employer must:

- Allow the employee to enroll without regard to open enrollment restrictions

Employer cannot:

Deny enrollment because the child:

- Was born outside of marriage
- Was not claimed as a dependent on the tax return
- Does not reside with employee

Terminate coverage for a child unless:

- Family health coverage is no longer available for all employees
- Child is enrolled in comparable coverage (must be confirmed with our office)
- A termination of NMSN is received from our office

Employer's Responsibilities

Within

40

Business Days

Employer must provide LCSA description of the coverage available along with any forms required for coverage:

- Employee's SSN and home address
- Name of insurance company, policy number and names of persons covered
- The information should be provided on the Health Insurance Information Form (available online)

Employer's Responsibilities

Within

10

Business Days

When there is a lapse or termination in coverage, notify LCSA within **10 business days:**

- Date coverage ended
- Reason for lapse
- When coverage is expected to resume if lapse is temporary
- This information should be provided on the Termination of Benefits/Employment Notice (available online)

There is no liability on the part of the employer for providing this information

Requirements

- Employee to maintain health insurance for the child at "reasonable or no cost"
- Employer to pay premiums directly to the insurance provider

Compliance/Timeframes

Within

10

Business Days

- of receipt, employer must notify the employee and provide employee with the Request and Notice of Hearing Regarding Health Insurance Assignment and provide instructions (obtained online)
- employer must notify the employee and provide employee with the Request and Notice of Hearing Regarding Health Insurance Assignment and provide instructions (obtained online)

Compliance/Timeframes

Within

20

Business Days

- after being served with the NMSN, the employer must forward instructions to enroll the employee's children to the health care plan administrator
- the employer must respond to the NMSN by completing and returning the Employer Response form with information regarding non-availability of coverage and whereabouts of former employee if known

Compliance/Timeframes

Within

40

Business Days

- the employer must furnish the LCSA a description of the coverage available along with forms required to activate coverage. This information should be submitted on the Health Insurance Information form (obtained online)

http://www.childsup.ca.gov/employer/tabid/56/default.aspx

Penalty for Non-Compliance

An employer who willfully fails to comply with the NMSN is

"liable to the Person Ordered to Receive Support (PRS) for the amount incurred in health care services that would otherwise have been covered by insurance."

Failure to comply is punishable by contempt

Types of Medical Support

- Medical
- Dental
- Vision
- Prescriptions
- Mental Health

Can be combined, single package, or separate policies or plans.

NMSN Cover Page Provides

- Subject line indicates enclosed documents
- Employee/Case Information
- Instructions and legal requirements employers must follow
- Contact and website information

Within **10** days of receiving the NMSN, provide the employee with a copy of:

- **NMSN Part A**
- **Statement of Obligor's Rights and Procedures** Regarding NMSN or Health Insurance Assignment Order
- **Request and Notice of Hearing** Regarding Health Insurance Assignment

National Medical Support Notice – Part A

This Notice is issued under section 466(a) (19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974 (ERISA), and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998. Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law. The information on the Custodial Parent and Child(ren) contained on this page is confidential and should not be shared or disclosed with the employee. NOTE: For purposes of this form, the Custodial Parent may also be the employee when the State opts to enforce against the Custodial Parent.

Issuing Agency: ORANGE DCSS
Issuing Agency Address: PO BOX 2209
SANTA ANA CA 92702-2099
Notice Date: 11/07/18
CSE Agency Case Identifier: 24681012
Telephone Number:(866)901-3212
FAX Number:(714)-347-4811

Court or Administrative Authority: SUPERIOR COURT
Order Date: 09/26/2019
Order Identifier: 23AB345678
Document Tracking Identifier:
Employer web site:
See NMSN Instructions:
http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form

12345678
Employer/Withholder's Federal EIN Number
LOONEY TOONEY LLC
Employer/Withholder's Name

321 CARTOONVILLE
ORANGE, CA 92701-4321
Employer / Withholder's Address

Custodial Parent's Name (Last, First, MI)

Custodial Parent's Mailing Address

Child(ren)'s Mailing Address (if different from Custodial Parent's)

Name and Telephone of a Representative of the Child(ren)

RE: MICE, TOM
Employee's Name (Last, First, MI)
222-22-2222
Employee's Social Security Number

11 ONLOCATE
ANIME, CA 01111-0001
Employee's Mailing Address

DEPARTMENT OF CHILD SUPPORT SERVICES CO
Substituted Official/Agency Name

PO BOX 22099 SANTA ANA CA 92702-2099
Substituted Official/Agency Address
(Required if Custodial Parent's mailing address is left blank)

Mailing Address of a Representative of the Child(ren)

Child(ren)'s Name(s)	Gender	DOB	SSN
MICKEY MICE	M	1/1/2008	xxx-

Child(ren)'s Name(s)	Gender	DOB	SSN

The order requires the child(ren) to be enrolled in | all health coverages available; or only the following coverage(s):
| Medical; | Dental; | Vision; | Prescription drug; | Mental health; | Other(specify):

THE PAPERWORK REDUCTION ACT OF 1995 (P.L. 104-13) Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. **OMB control number: 0970-0222. Expiration Date: 08/31/2019.**

DR

Within **20** business days of receiving NMSN, the employer must:

Complete **Employer Response**, if applies

OR

Forward **Part B** to **Plan Administrator**, if health insurance is available at a reasonable cost

EMPLOYER RESPONSE

If 1, 2, 3, 4 or 5 below applies, check the appropriate box and return this Part A to the Issuing Agency within 20 business days after the date of the Notice, or sooner if reasonable. NO OTHER ACTION IS NECESSARY. If 1 through 5 does not apply, complete item 7 and forward **Part B** to the appropriate Plan Administrator(s) within 20 business days after the date of the Notice, or sooner if reasonable. This includes any organization or labor union that provides group health care benefits to the employee. Check number 5 and return this **Part A** to the **Issuing Agency** if the Plan Administrator informs you that the child(ren) would be enrolled in or qualify(ies) for an option under the plan for which you have determined that the employee contribution exceeds the amount that may be withheld from the employee's income due to State or Federal withholding limitations and/or prioritization. You are required to respond to the Issuing Agency by returning this **Employer Response** regardless of whether you provide group health benefits or the employee named herein is no longer employed by your organization. Information for the Plan Administrator and the Employer Representative at the bottom of this section is required.

☐ 1. The employee named in this Notice has never been employed by this employer.

☐ 2. We, the employer, do not offer our employees the option of purchasing dependent or family health care coverage as a benefit of their employment.

☐ 3. The employee is among a class of employees (for example, parttime or non-union) that are not eligible for family health coverage under any group health plan maintained by the employer or to which the employer contributes. Do not check this box if the employee is only temporarily ineligible for health care coverage.

☐ 4. Health care coverage is not available because employee is no longer employed by the employer:

Date of termination: _____

Last known telephone number: _____

Last known address: _____

New employer (if known): _____

New employer telephone number: _____

New employer address: _____

☐ 5 State or Federal withholding limitations and/or prioritization prevent the withholding from the employee's income of the amount required to obtain coverage under the terms of the plan.

☐ 6 The participant is subject to a waiting period that expires _____ (more than 90 days from the date of receipt of this Notice), or has not completed a waiting period, which is determined by some measure other than the passage of time, such as the completion of a certain number of hours worked (describe here: _____). At the completion of the waiting period, the Plan Administrator will process the enrollment.

☐ 7 Employer forwarded Part B to Plan Administrator on _____.
MM/DD/YY

CONTACT FOR QUESTIONS

Plan Administrator Name: _____
Contact Person: _____

Employer Name: LOONEY TOONEY LLC
Employer Representative Name/Title: _____

Employee Name: TOM MICE 003691215

FAX Number: _____
Telephone Number: _____

Telephone Number: _____
Federal EIN: _____
(if not provided on Page 1 of this Notice)
Date: _____

DR

Amount Listed for "Current Medical Support" on IWO

You may receive an IWO that includes Cash Medical

ORDER INFORMATION: This document is based on the support or withholding order from _____ (State/Tribe).
You are required by law to deduct these amounts from the employee/obligor's income until further notice.

$ _____ Per _____ current child support
$ _____ Per _____ past-due child support - **Arrears greater than 12 weeks?** ☐ Yes ☐ No
$ _____ Per _____ current cash medical support
$ _____ Per _____ past-due cash medical support
$ _____ Per _____ current spousal support
$ _____ Per _____ past-due spousal support
$ _____ Per _____ other (must specify) _____

for a **Total Amount to Withhold** of $_____ per _____.

AMOUNTS TO WITHHOLD: You do not have to vary your pay cycle to be in compliance with the *Order Information*. If your pay cycle does not match the ordered payment cycle, withhold one of the following amounts:

$ _____ per weekly pay period $ _____ per semimonthly pay period (twice a month)
$ _____ per biweekly pay period (every two weeks) $ _____ per monthly pay period
$ _____ **Lump Sum Payment:** Do not stop any existing IWO unless you receive a termination order.

REMITTANCE INFORMATION: If the employee/obligor's principal place of employment is _____ (State/Tribe), you must begin withholding no later than the first pay period that occurs _____ days after the date of _____. Send payment within _____ working days of the pay date. If you cannot withhold the full amount of support for any or all orders for this employee/obligor, withhold up to _____% of disposable income for all orders. If the employee/obligor's principal place of employment is not _____ (State/Tribe), obtain withholding limitations, time requirements, and any allowable employer fees at http://www.acf.hhs.gov/programs/cse/newhire/employer/contacts/contact_map.htm for the employee/obligor's principal place of employment.

Document Tracking Identifier _____ 1

- Specific dollar amount
- Used by PRS to pay health cost and/or unreimbursed medical

Live Poll

My employee can't afford health insurance. What do I do?

50% Withholding Limitations

- Deducting costs of health insurance coverage in addition to the child support amount CANNOT exceed 50% of the employee's net disposable income

- Notify LCSA if limitations on withholding prevent completion of health insurance enrollment

Current Support and Health Insurance Less than MSD

Net Disposable Income	$662
x	50%
Maximum Support Deduction	$331

	CS	H/I	Total
Ordered	$150	$ 50	$200
Allocate	$150	$ 50	$200

Current Support and Health Insurance More than MSD

Net Disposable Income	$662
x	50%
Maximum Support Deduction	$331

	CS	H/I	Total
Ordered	$300	$ 50	$350
Allocate	$300	$ 0	$300

In this example, employer should complete Item 5 of the Employer Response form and return it to the LCSA

5% Income Limitations

- Reasonable if cost is not more that 5% of your employee's gross income
- Cost is the difference between individual coverage and coverage including dependents

Example:

Obligor's gross monthly income	$2000
5% of gross monthly income	$ 100
Cost to insure self only	$ 50/month
Cost for family coverage	$250
Difference	$200
The additional cost exceeds 5% of gross monthly income	$200>100

- Primary health care services must be within the 50 mile radius
- If the child lives outside the coverage area the policy is inaccessible

Applying the Withholding Order of Priority

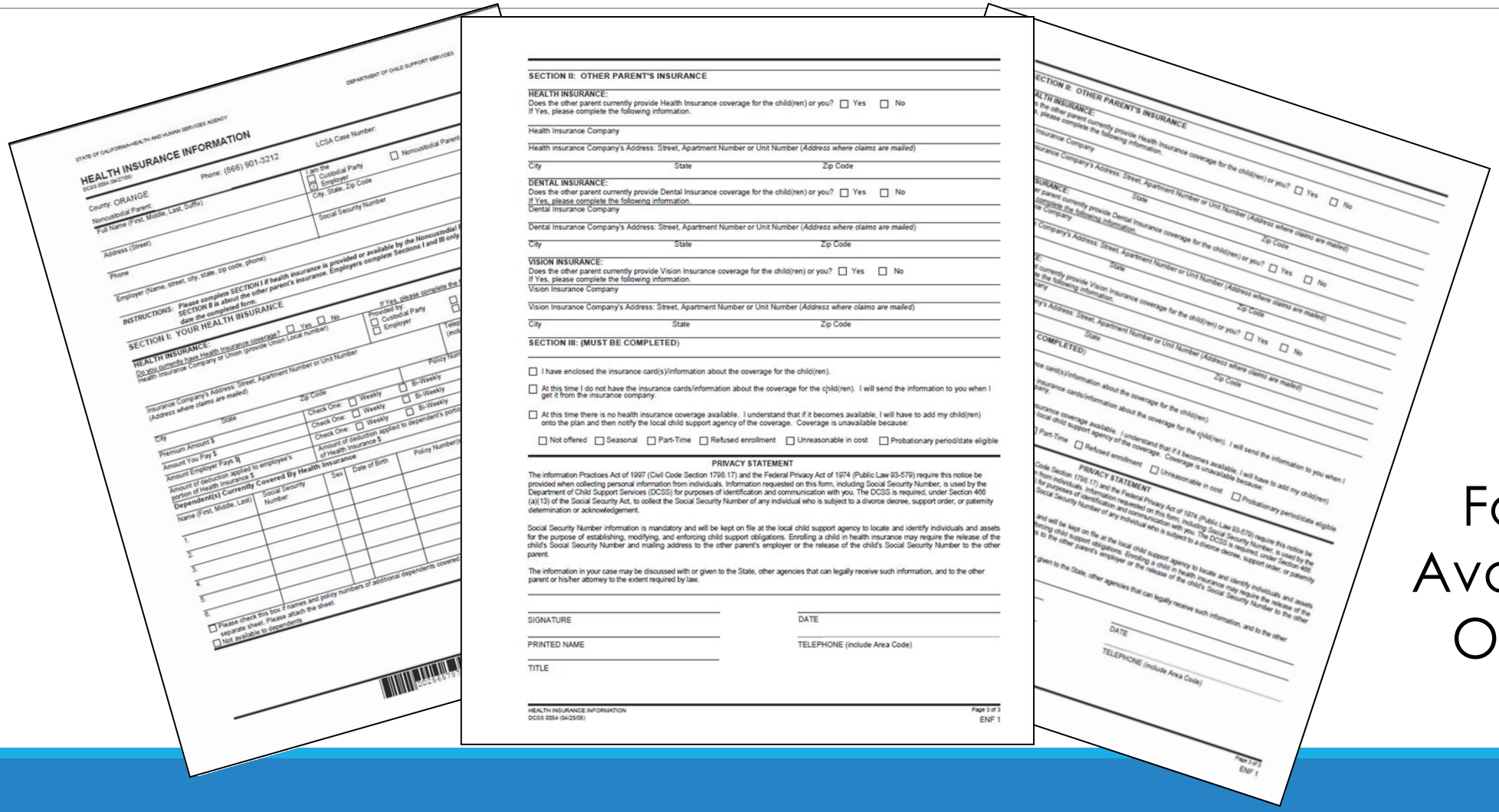
- Current Child/Family Support
- Medical Support if on IWO
- Current Spousal Support
- Health Insurance Premium
- Child/Family Support Arrears
- Spousal Support Arrears

Current child support always takes priority over other deductions
(with possible exception of IRS tax liens)

Live Poll

Do I need to honor the NMSN if the child already has health insurance?

Health Insurance Information Forms



Forms Available Online

Why send coverage info to LCSA?

- LCSA is the designated "substituted official/agency" on Part B of the NMSN
- Forwarding all health insurance coverage materials, such as insurance cards, copies of policies ensures the confidentiality of PRS' information

Participant and Health Insurance Information

STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF CHILD SUPPORT SERVICES

HEALTH INSURANCE INFORMATION

DCSS 0054 (04/27/2005)

County: Phone: 866-901-3212 LCSA Case Number:

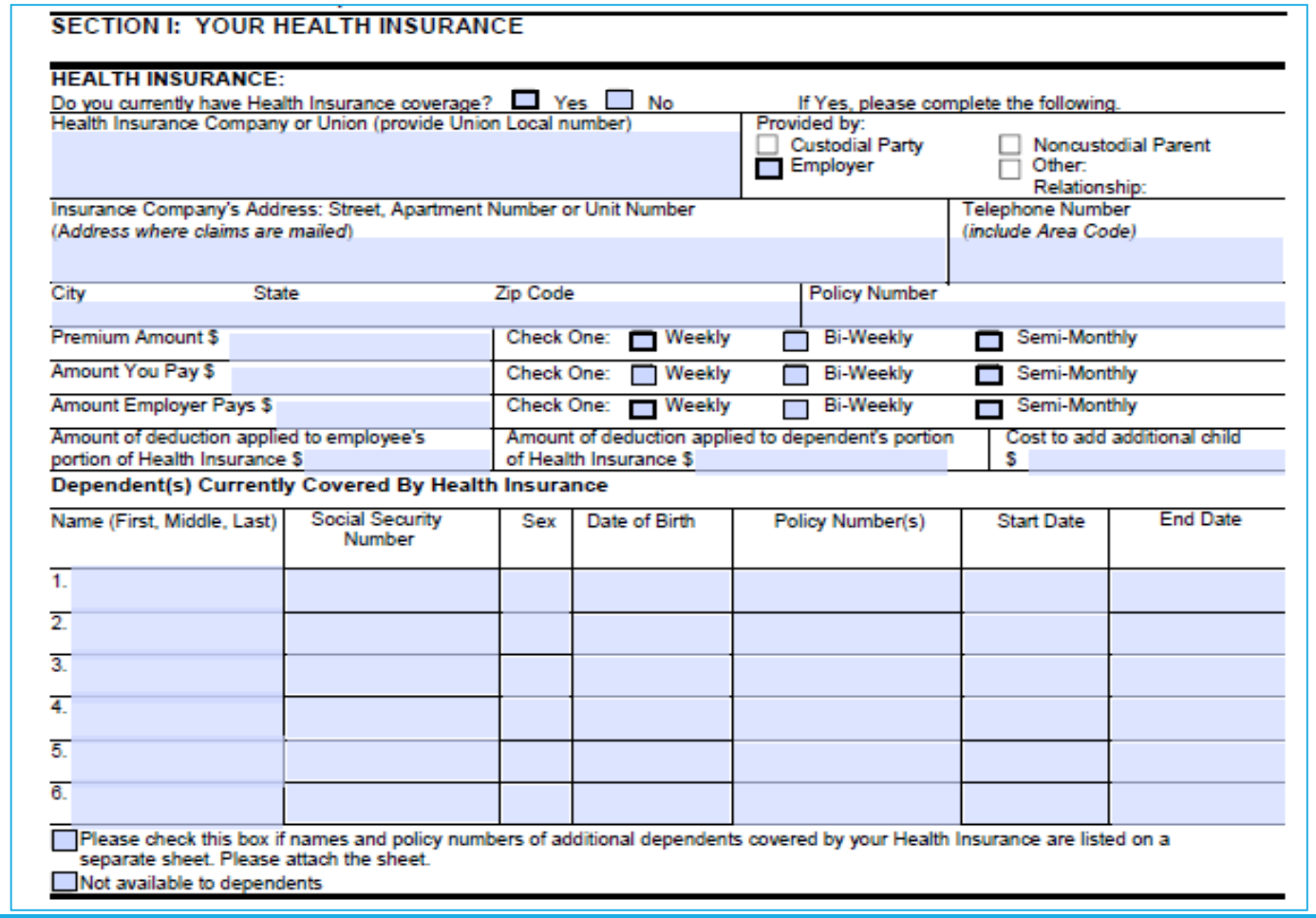
Noncustodial Parent:

Full Name (First, Middle, Last, Suffix)	I am the ☐ Custodial Party ☐ Noncustodial Parent ☐ Employer
Address (Street)	City, State, Zip Code
Phone	Social Security Number

Employer (Name, street, city, state, zip code, phone)

INSTRUCTIONS: ***Please complete SECTION I if health insurance is provided or available by the Noncustodial Parent or employer. SECTION II is about the other parent's insurance. Employers complete Sections I and III only. Please sign and date the completed form.***

Participant and Health Insurance Information



SECTION I: YOUR HEALTH INSURANCE

HEALTH INSURANCE:

Do you currently have Health Insurance coverage? ☒ Yes ☐ No If Yes, please complete the following.

Health Insurance Company or Union (provide Union Local number)	Provided by: ☐ Custodial Party ☐ Noncustodial Parent ☒ Employer ☐ Other: Relationship:
Insurance Company's Address: Street, Apartment Number or Unit Number (*Address where claims are mailed*)	Telephone Number (*include Area Code*)
City / State / Zip Code	Policy Number
Premium Amount $	Check One: ☒ Weekly ☐ Bi-Weekly ☒ Semi-Monthly
Amount You Pay $	Check One: ☐ Weekly ☐ Bi-Weekly ☒ Semi-Monthly
Amount Employer Pays $	Check One: ☒ Weekly ☐ Bi-Weekly ☒ Semi-Monthly
Amount of deduction applied to employee's portion of Health Insurance $	Amount of deduction applied to dependent's portion of Health Insurance $ / Cost to add additional child $

Dependent(s) Currently Covered By Health Insurance

Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	Policy Number(s)	Start Date	End Date
1.						
2.						
3.						
4.						
5.						
6.						

☐ Please check this box if names and policy numbers of additional dependents covered by your Health Insurance are listed on a separate sheet. Please attach the sheet.

☐ Not available to dependents

Dental Insurance Information

DENTAL INSURANCE:

Do you currently have Dental Insurance coverage? ☐ Yes ☐ No If Yes, please complete the following.

Dental Insurance Company

Dental Insurance Company's Address: Street, Apartment Number or Unit Number (*address where claims are mailed*)

City	State	Zip Code	Policy Number

Premium Amount $	Check One: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly
Amount You Pay $	Check One: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly
Amount Employer Pays $	Check One: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly

Amount of deduction applied to employee's portion of Health Insurance $	Amount of deduction applied to dependent's portion of health insurance $	Cost to add additional child $

Dependent(s) Covered by Dental Insurance

Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	Policy Number(s)	Start Date	End Date
1.						
2.						
3.						
4.						
5.						
6.						

☐ Please check this box if names and policy numbers of additional dependents covered by your Dental Insurance are listed on a separate sheet of paper. Please attach the sheet.

☐ Not available to dependents

Vision Insurance

VISION INSURANCE:

Do you currently have Vision Insurance coverage? ☐ Yes ☐ No If Yes, please complete the following.

Vision Insurance Company

Vision Insurance Company's Address: Street, Apartment Number or Unit Number (*Address where claims are mailed*)

City	State	Zip Code	Policy Number

Premium Amount $	Check One: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly
Amount You Pay $	Check One: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly
Amount Employer Pays $	Check One: ☐ Weekly	☐ Bi-Weekly	☐ Semi-Monthly

Amount of deduction applied to employee's portion of Health Insurance $	Amount of deduction applied to dependent's portion of health insurance $	Cost to add additional child $

Dependent(s) Covered by Vision Insurance

Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	Policy Number(s)	Start Date	End Date
1.						
2.						
3.						
4.						
5.						
6.						

☐ Please check this box if names and policy numbers of additional dependents covered by your Vision Insurance are listed on a separate sheet. Please attach the sheet.

☐ Not available to dependents

Certification

SECTION III: (MUST BE COMPLETED)

☐ I have enclosed the insurance card(s)/information about the coverage for the child(ren).

☐ At this time I do not have the insurance cards/information about the coverage for the child(ren). I will send the information to you when I get it from the insurance company.

☐ At this time there is no health insurance coverage available. I understand that if it becomes available, I will have to add my child(ren) onto the plan and then notify the local child support agency of the coverage. Coverage is unavailable because:

☐ Not offered ☐ Seasonal ☐ Part-Time ☐ Refused enrollment ☐ Unreasonable in cost ☐ Probationary period/date eligible

PRIVACY STATEMENT

The information Practices Act of 1997 (Civil Code Section 1798.17) and the Federal Privacy Act of 1974 (Public Law 93-579) require this notice be provided when collecting personal information from individuals. Information requested on this form, including Social Security Number, is used by the Department of Child Support Services (DCSS) for purposes of identification and communication with you. The DCSS is required, under Section 466 (a)(13) of the Social Security Act, to collect the Social Security Number of any individual who is subject to a divorce decree, support order, or paternity determination or acknowledgement.

Social Security Number information is mandatory and will be kept on file at the local child support agency to locate and identify individuals and assets for the purpose of establishing, modifying, and enforcing child support obligations. Enrolling a child in health insurance may require the release of the child's Social Security Number and mailing address to the other parent's employer or the release of the child's Social Security Number to the other parent.

The information in your case may be discussed with or given to the State, other agencies that can legally receive such information, and to the other parent or his/her attorney to the extent required by law.

SIGNATURE

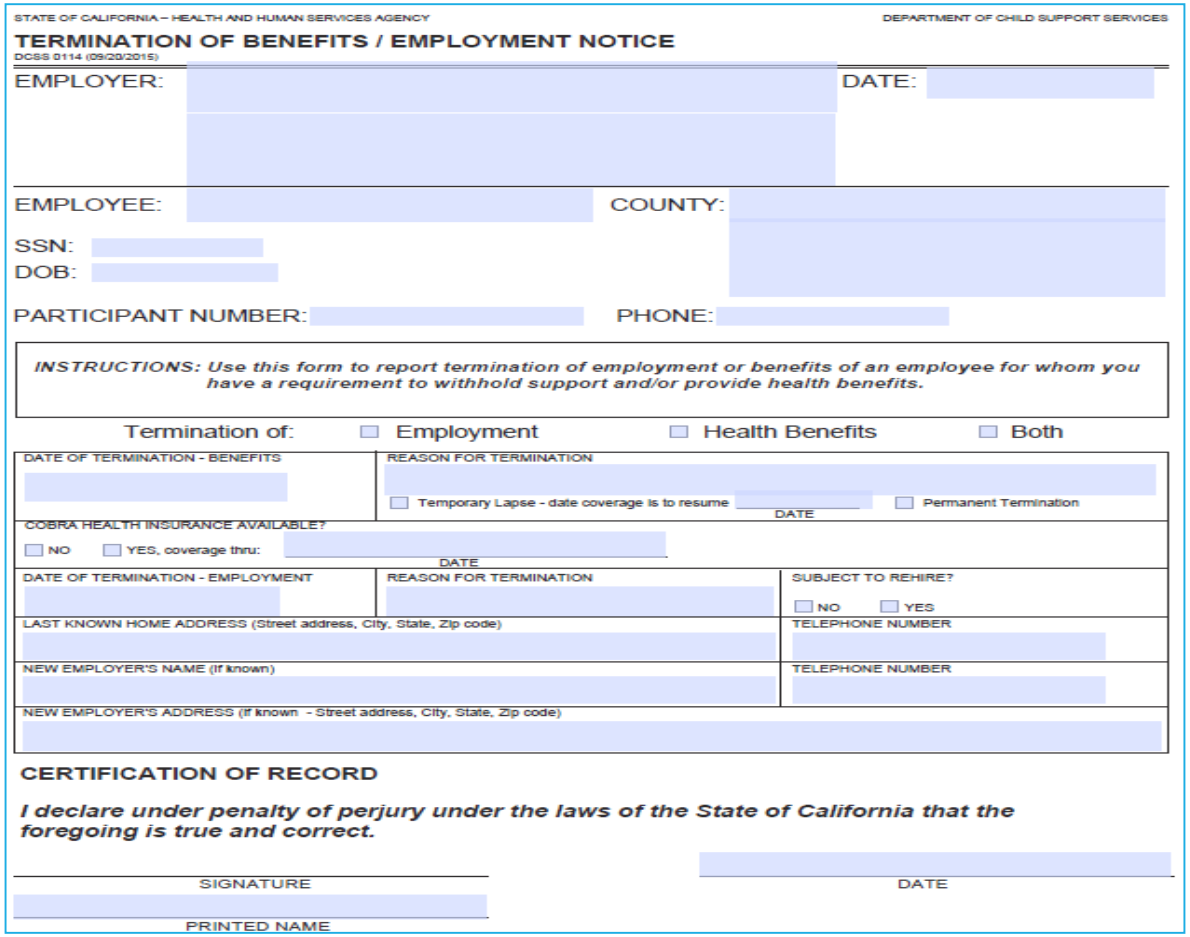
DATE

PRINTED NAME

TELEPHONE (include Area Code)

TITLE

Termination of Benefits/Employment Notice



STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF CHILD SUPPORT SERVICES

TERMINATION OF BENEFITS / EMPLOYMENT NOTICE

DCSS 0114 (09/20/2015)

EMPLOYER: DATE:

EMPLOYEE: COUNTY:

SSN:

DOB:

PARTICIPANT NUMBER: PHONE:

INSTRUCTIONS: Use this form to report termination of employment or benefits of an employee for whom you have a requirement to withhold support and/or provide health benefits.

Termination of: ☐ Employment ☐ Health Benefits ☐ Both

DATE OF TERMINATION - BENEFITS

REASON FOR TERMINATION

☐ Temporary Lapse - date coverage is to resume DATE ☐ Permanent Termination

COBRA HEALTH INSURANCE AVAILABLE?

☐ NO ☐ YES, coverage thru: DATE

DATE OF TERMINATION - EMPLOYMENT

REASON FOR TERMINATION

SUBJECT TO REHIRE?

☐ NO ☐ YES

LAST KNOWN HOME ADDRESS (Street address, City, State, Zip code)

TELEPHONE NUMBER

NEW EMPLOYER'S NAME (If known)

TELEPHONE NUMBER

NEW EMPLOYER'S ADDRESS (If known - Street address, City, State, Zip code)

CERTIFICATION OF RECORD

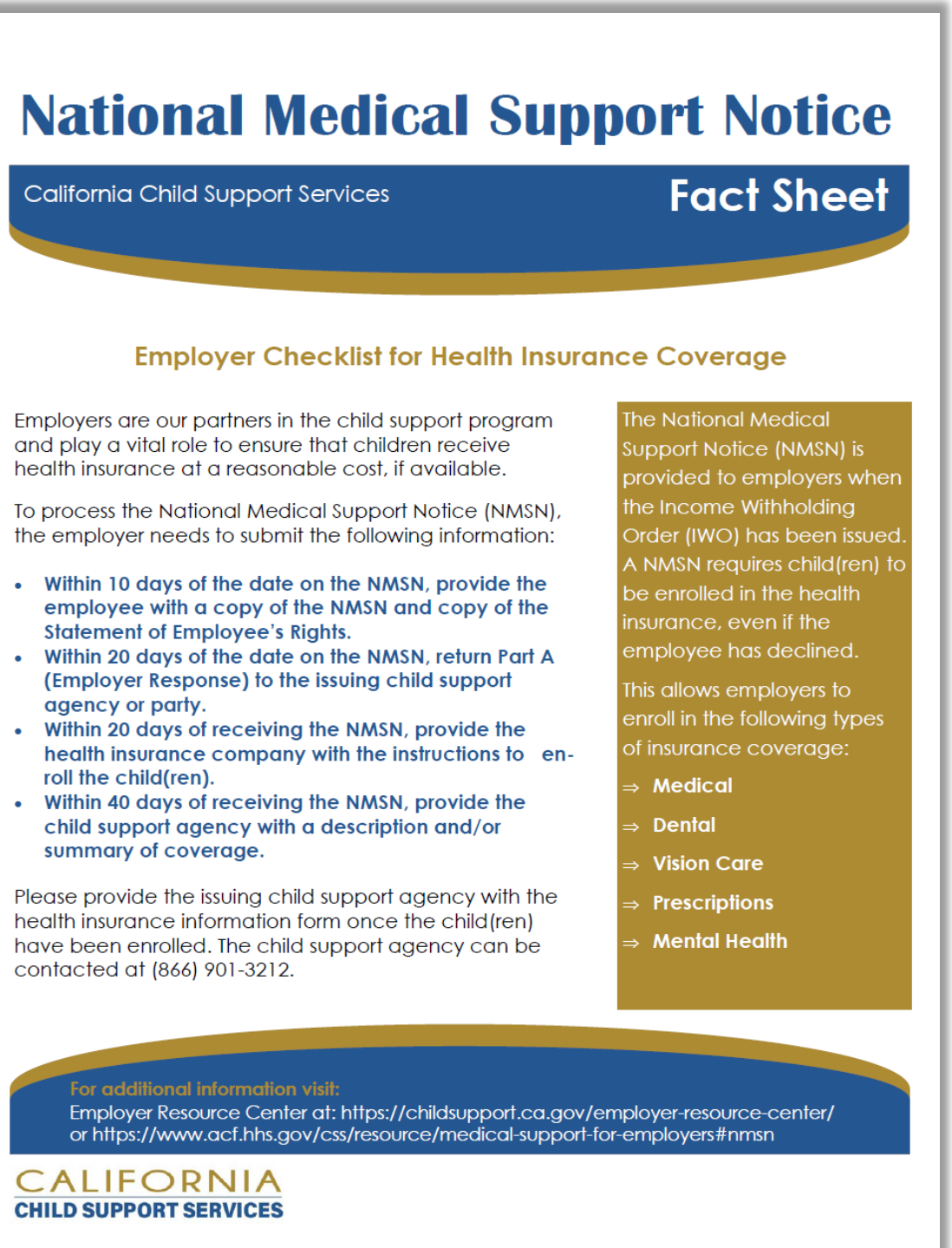
I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

SIGNATURE

DATE

PRINTED NAME

NMSN Fact Sheet



National Medical Support Notice

California Child Support Services **Fact Sheet**

Employer Checklist for Health Insurance Coverage

Employers are our partners in the child support program and play a vital role to ensure that children receive health insurance at a reasonable cost, if available.

To process the National Medical Support Notice (NMSN), the employer needs to submit the following information:

- **Within 10 days of the date on the NMSN, provide the employee with a copy of the NMSN and copy of the Statement of Employee's Rights.**
- **Within 20 days of the date on the NMSN, return Part A (Employer Response) to the issuing child support agency or party.**
- **Within 20 days of receiving the NMSN, provide the health insurance company with the instructions to enroll the child(ren).**
- **Within 40 days of receiving the NMSN, provide the child support agency with a description and/or summary of coverage.**

Please provide the issuing child support agency with the health insurance information form once the child(ren) have been enrolled. The child support agency can be contacted at (866) 901-3212.

The National Medical Support Notice (NMSN) is provided to employers when the Income Withholding Order (IWO) has been issued. A NMSN requires child(ren) to be enrolled in the health insurance, even if the employee has declined.

This allows employers to enroll in the following types of insurance coverage:

⇒ **Medical**

⇒ **Dental**

⇒ **Vision Care**

⇒ **Prescriptions**

⇒ **Mental Health**

For additional information visit:
Employer Resource Center at: https://childsupport.ca.gov/employer-resource-center/
or https://www.acf.hhs.gov/css/resource/medical-support-for-employers#nmsn

CALIFORNIA
CHILD SUPPORT SERVICES

DR -> LF

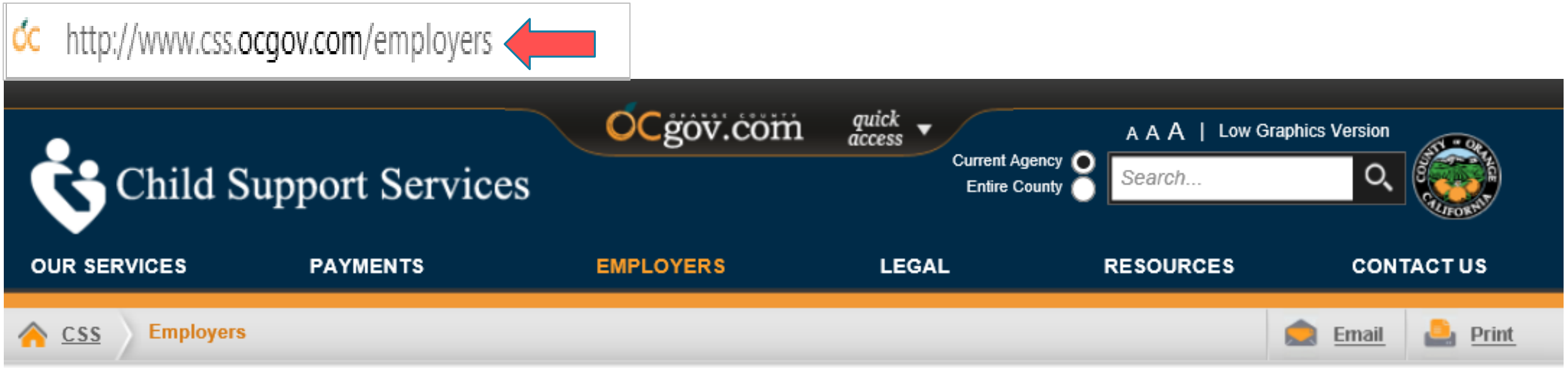
Website Demonstration

Website Demonstration

- CSS Webpage
  www.css.ocgov.com/employer

- DCSS Webpage
  www.childsupport.ca.gov

CSS Website/Employer Page Sign-In

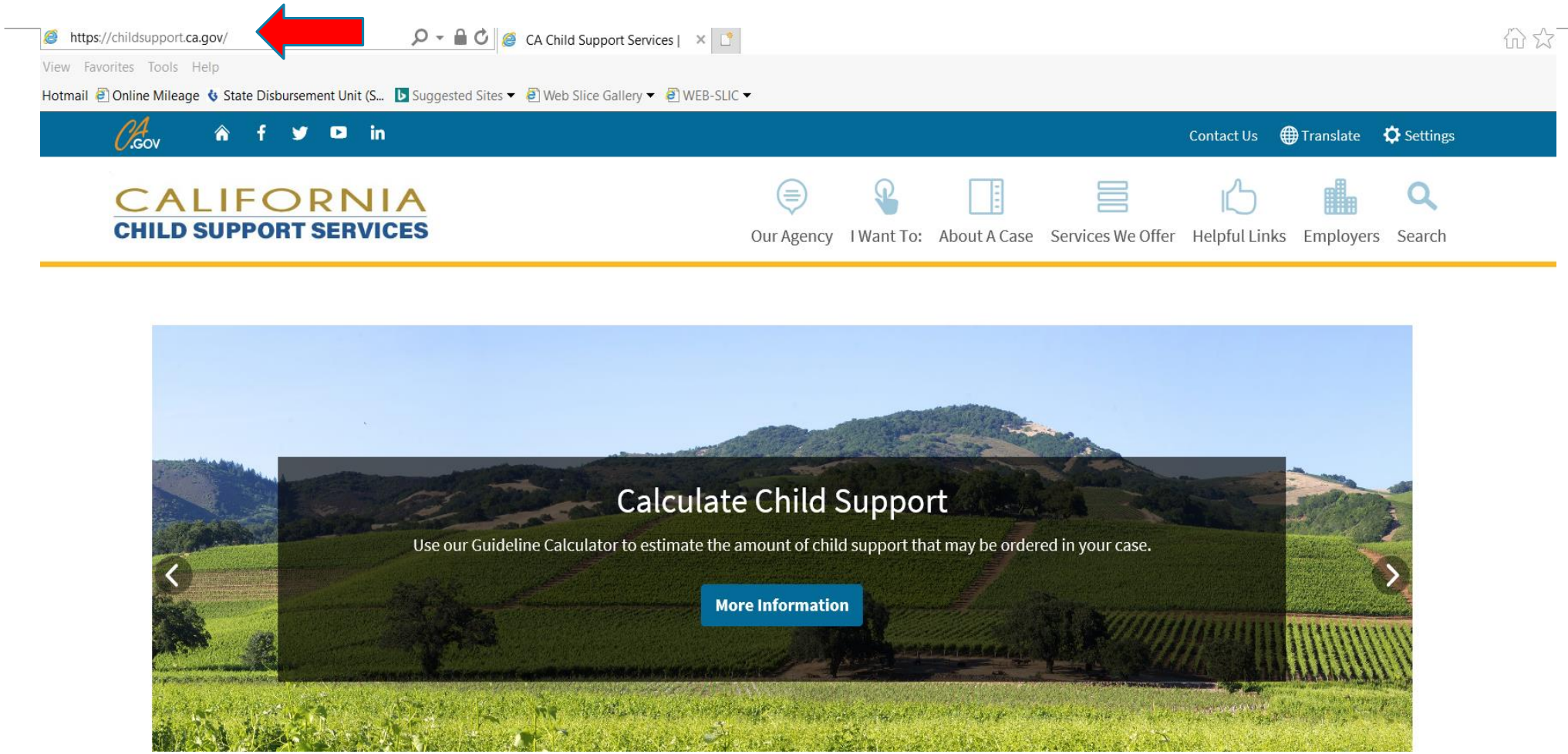


WEBSITE DEMONSTRATION

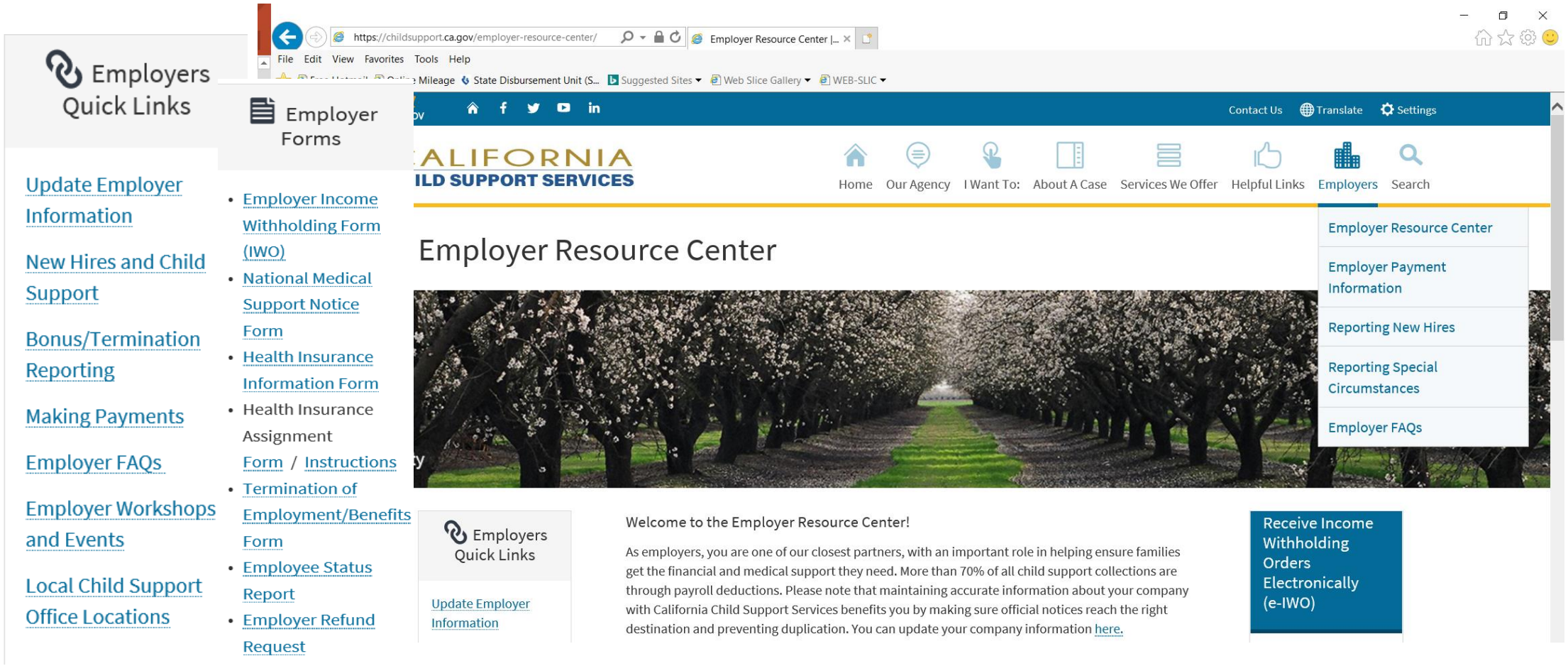
EMPLOYER PAGE

LF

DCSS Website Sign-In



DCSS Website - Employer Page



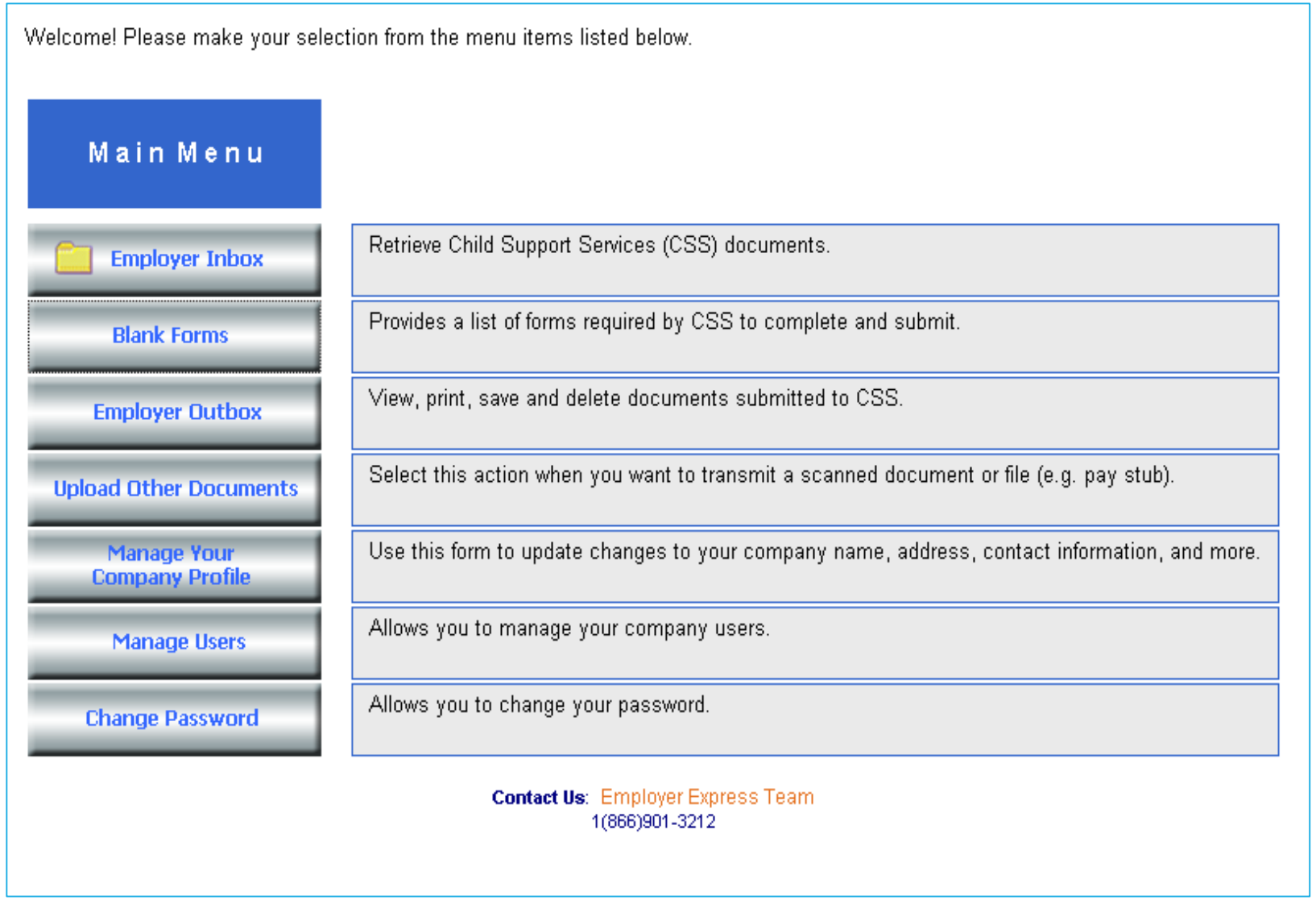
CSS Employer Portal

What is the CSS Employer Portal?

- Secure exchange of confidential information
- Sharing information is fast and cost saving
- Training and User Guide available on Employer webpage
- Get started is easy and free

CSS EMPLOYER PORTAL

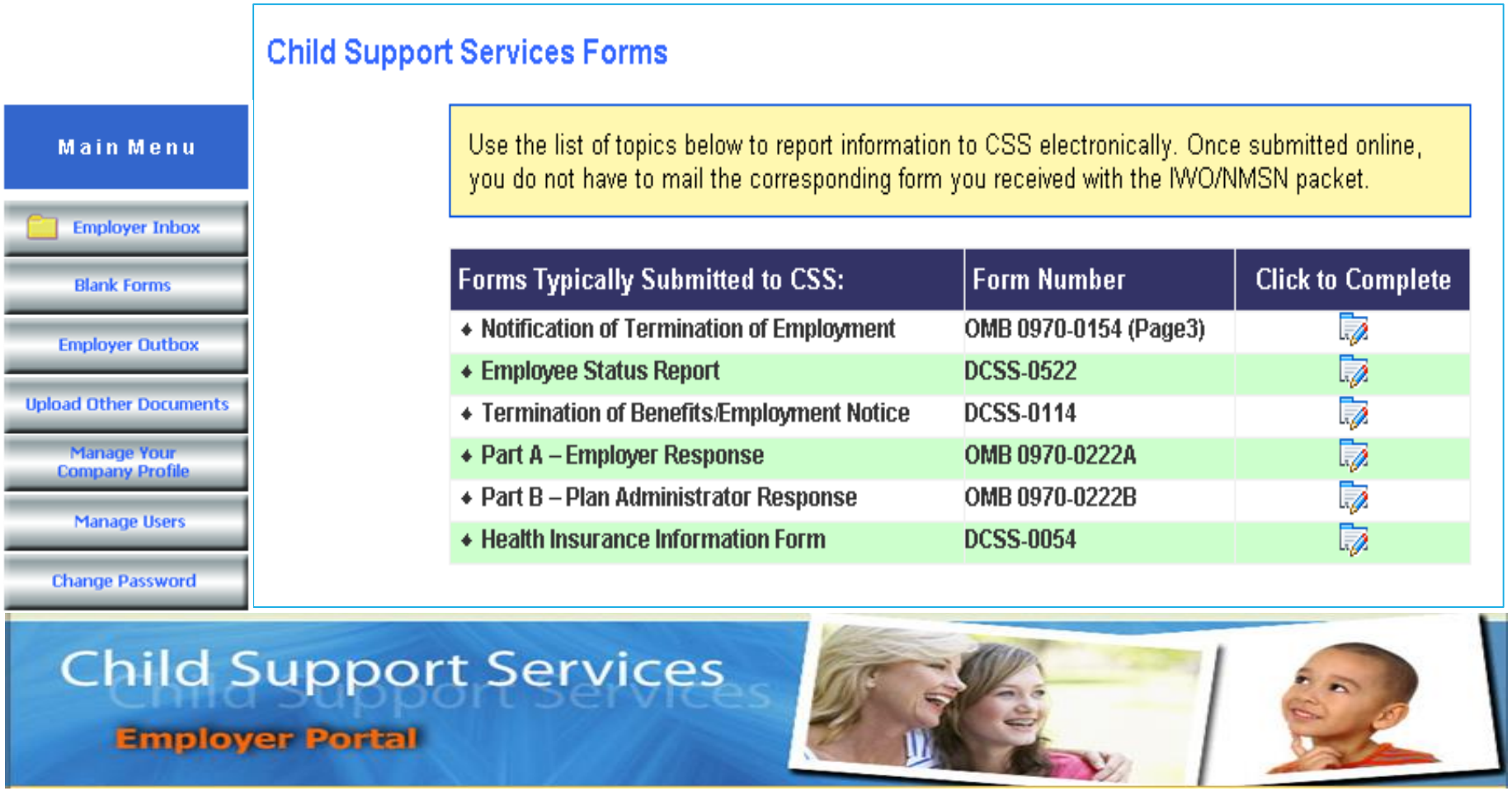
MAIN MENU



AC

Inbox/Outbox

Blank Forms


Main Menu
Employer Inbox
Blank Forms
Employer Outbox
Upload Other Documents
Manage Your Company Profile
Manage Users
Change Password
Child Support Services Forms
Use the list of topics below to report information to CSS electronically. Once submitted online, you do not have to mail the corresponding form you received with the IWO/NMSN packet.
Forms Typically Submitted to CSS:
Form Number
Click to Complete
Notification of Termination of Employment
OMB 0970-0154 (Page3)
Employee Status Report
DCSS-0522
Termination of Benefits/Employment Notice
DCSS-0114
Part A – Employer Response
OMB 0970-0222A
Part B – Plan Administrator Response
OMB 0970-0222B
Health Insurance Information Form
DCSS-0054
Child Support Services
Employer Portal

Employer Contacts

For statewide child support information call: (866) 901-3212

Employer Express
Orange County Department of Child Support Services
1055 N. Main Street
Santa Ana, CA 92701

Mailing:
P.O. Box 22099
Santa Ana, CA 92702

(714) 347-8200 Fax

Email: CSS-EmployerExpressTeam@css.ocgov.com
Website: www.css.ocgov.com/employers

California Department of Child Support Services
Website: www.childsupport.ca.gov

California State Disbursement Unit (SDU)
P.O. Box 989067
West Sacramento, CA 95798-9067

(888) 851-6317 Replacement Payment-NSF Line
(866) 900-6656 Private Cases

Email: casdu-electronichelpdesk@dcss.ca.gov
Website: www.casdu.com

Employment Development Department
(888) 745-3886

Email: eddservices.edd.ca.gov

Website: www.edd.ca.gov

For information about e-IWO visit: acf.hhs.gov/programs/css/employers/e-iwo

Employers are critical partners in helping families receive the financial and medical support they need.

AC -> DR

Speaker Contact Information

David Ruvalcaba
Administrative Manager II
Case Operations
Druvalcaba@css.ocgov.com
(714) 347-6916

Aidee Cooksey
Supervising Child Support Specialist
Employer Express Team
ACooksey@css.ocgov.com
(714) 347-4959

Lynette Favors
Administrative Manager I
Special Collections
LFavors@css.ocgov.com

(714) 347-4830

Angela Jones
Employer Outreach Coordinator
California Child Support Services
Angela.Jones@dcss.ca.gov
(916) 464-1797

Thank you for attending!

- FAQs
- Questions via chat
- Resources/Recording
- Next day survey
  CSS-EmployerExpressTeam@css.ocgov.com