# 2017 EMPLOYER WORKSHOP


## Handouts

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Report of New Employee(s)

Report of Independent Contractor(s)

Wage and Insurance Verification

Income Withholding Order (IWO)

Termination of Benefits / Employment Notice

Employee Status Report

Health Insurance Information

National Medical Support Notice (NMSN)

# WAGE WITHHOLDING

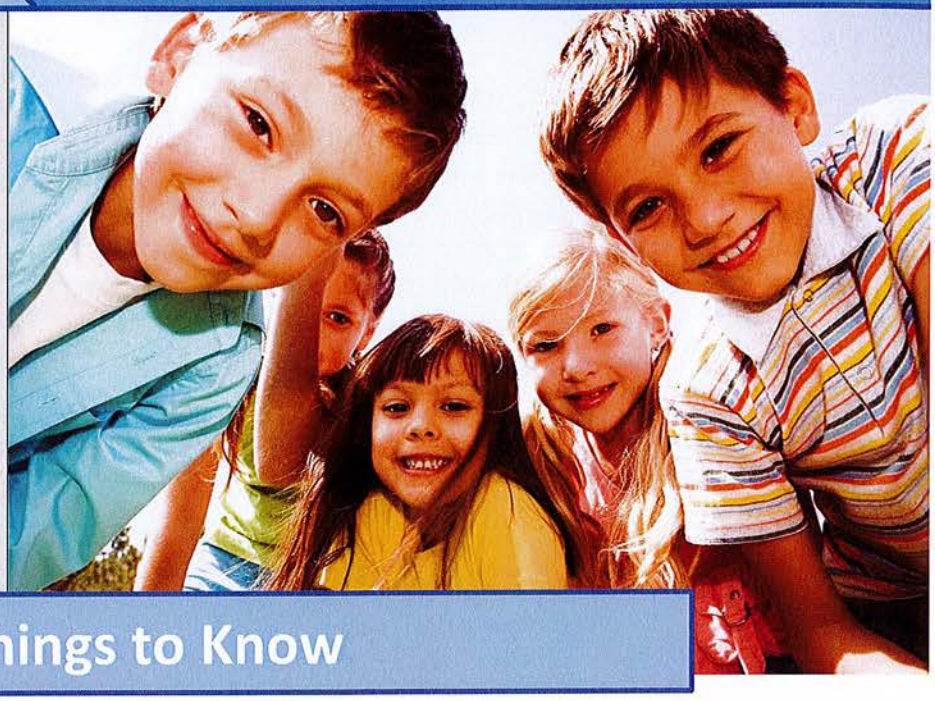
Visit our website: www.childsup.ca.gov/employer.aspx
Contact our Call Center: 866-901-3212

**Once an Income Withholding Order (IWO) is received, please go to our website above to complete the Employee Status Report, located under Employer Forms.**

**This form should be forwarded to the local child support agency (LCSA) within 10 working days of receipt of the Income Withholding Order (IWO).**

**Have Questions?**

**Our Call Center is available Monday – Friday**



## Things to Know

### What Are Earnings?

- Wages/Salary
- Bonuses
- Commissions
- Vacation Pay
- Dividends
- Royalties
- Retirement
- Payment for Independent Contractor

** Earnings defined by Family Code Section 5206*

### Calculating the Maximum Support Deduction

To determine the maximum support deduction use the following calculation:

IWO + Health Insurance premium = Net Pay x 50%

Report bonus or lump payments prior to issuing payment by contacting CA DCSS: lumpsumresponesteam@dcss.ca.gov or ph#916-464-6640

### Multiple Garnishments are paid in the following order:

1. Child Support IWO
2. Bankruptcy Order
3. Federal Admin Garnishment
4. Federal Tax Levy*
5. Student Loan
6. State Tax Levy
7. Local Tax Levy
8. Creditor Garnishments
9. Employer deductions

** Priority of the Child Support IWO and Federal Tax Levy can vary, please contact the LCSA*

## What to Do

**Withhold support payments no later than the 1st pay period occurring 10 working days after being served with the Income Withholding Order (IWO).**

**Please include 2 identifiers for the employee on the payment stub or check:**

- **Name**
- **Social Security Number**
- **Case Number**
- **Participant ID Number**

*** Include the legal date of collection**

**Send support payments within 7 working days to:**

**CA State Disbursement Unit (SDU)**
**PO Box 989067**
**West Sacramento, CA 95798**
**OR**
**submit online:**
**www.CASDU.com**

# HEALTH INSURANCE

Visit our website: www.childsup.ca.gov/employer.aspx
Contact our Call Center: 866-901-3212

**Once child(ren) are enrolled in health insurance coverage, coverage should continue until further notice from the local child support agency.**

**If the employee feels cost of health insurance is unreasonable, please encourage the employee to contact his/her local child support agency.**

**Have Questions?**

**Our Call Center is available Monday – Friday**

## Things to Know

### What Is Medical Support?

Court ordered dependent health insurance coverage includes:

- Medical
- Dental
- Vision Care
- Prescription
- Mental Health

### Is the Cost of the Medical Coverage Reasonable for the Employee?

The cost of the coverage is deemed reasonable if:

The cost to add the child does not exceed 5% of the employee's gross income

*OR*

The cost of the coverage plus the IWO does not exceed 50% of the employee's net pay

### Lapse in Coverage

- Provide date coverage ended/Reason for lapse
- Date coverage is expected to resume *(if applicable)*
- Inform child support agency if coverage is not available due to probationary period
- Notify if limitations on withholding prevent health insurance enrollment

## What to Do

**#1**

**Within 10 business days of receiving the National Medical Support Notice (NMSN), employee must be notified that the document was received.**

**#2**

**Within 20 business days of receiving the National Medical Support Notice (NMSN), Part B must be forwarded to the health care plan administrator.**

**#3**

**Within 40 business days of receiving the National Medical Support Notice (NMSN), provide the local child support agency with a description of the coverage (i.e. provider/policy information).**

**Begin withholding any employee contributions as required.**

| RESOURCES | |
|---|---|
| **Questions about the Wage Withholding/ Medical Support Notice** | Contact the Local Child Support Agency at 866-901-3212 |
| **Employer Resource Center** | Reference material, forms, FAQs and more are available online at: www.childsup.ca.gov/employer.aspx |
| **Federal Office of Child Support Enforcement (e-IWO)** | Questions regarding e-IWO, visit: www.childsup.ca.gov/employer/electronicincomewithholdingorders(e-iwo).aspx<br>Contact: Bill Stuart, e-mail: eiwomail@acf.hhs.gov |
| **Bonus/Lump Sum Reporting** | Report bonus or lump payments prior to pay-out by contacting CA DCSS via e-mail: lumpsumresponseteam@dcss.ca.gov or phone 916-464-6640 |
| **Debt Inquiry Service (DIS)** | For information on the Lump Sum Reporting application and eTerm application visit: www.acf.hhs.gov/programs/css/resource/debt-inquiry-service-for-employers |
| **Terminated Employees** | Report terminated employees to the Local Child Support Agency. For electronic reporting contact the Federal Employer Service Team via e-mail: employerservices@acf.hhs.gov |
| **Employment Development Department e-Services** | https://eddservices.edd.ca.gov/ |
| **Employer Contact Information** | Update your company information electronically at: www.childsup.ca.gov/employer/employerinformation.aspx<br>or Contact the DCSS Employer Services Team at 888-898-1743 |
| **State Level Employer Services Contact** | Ryan Micka, e-mail: ryan.micka@dcss.ca.gov |
| **REMITTING PAYMENTS** | |
| **Mail** | State Disbursement Unit<br>P.O. Box 989067<br>West Sacramento, CA 95798-9067 |
| **Phone** | 866-901-3212 (Option 1). Debit/Credit Card or Bank Account information will be needed |
| **Online** | www.childsup.ca.gov<br>Debit/Credit Card or Bank Account information will be needed |
| **Electronic Funds Transfer** | Employers instruct their financial institution to transmit child support payments using the Automated Clearing House (ACH) Network.<br>Call 866-901-3212 (Option 1) for assistance with initial set-up |
| **Request Stop Payment** | Contact the NSF Recovery Unit before issuing a stop payment on a remitted check. Contact 888-851-6317 or send an e-mail to: dcssnsfstoppay@dcss.ca.gov |

**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

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

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

MAIL TO: Employment Development Department / PO Box 997016, MIC 96
West Sacramento, CA 95799-7016 or fax to 916-319-4400

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## INSTRUCTIONS FOR COMPLETING ALL OF THE ELEMENTS ON THE *REPORT OF NEW EMPLOYEE(S),* DE 34

### REQUIREMENTS:

**Federal law requires all employers to report all newly hired employees, who work in California, to the Employment Development Department (EDD) within 20 days of their start-of-work date, which is the first day of work. In addition, any employee who is rehired after a separation of at least 60 consecutive days must also be reported within the 20 days. State and county agencies use this information to assist them in locating parents who are delinquent in their child support obligations.**

### PENALTIES:

**Employers who fail to report the hiring or rehiring of an employee, as required and within the time frame required, may be assessed a penalty of $24 for each failure to report or $490 if the failure to report is an intentional agreement between the employer and employee to not supply the required information or to supply a false or incomplete report.**

### WHAT MUST BE REPORTED ON THIS FORM:

**Employer's:**

- California employer payroll tax account number ***on each form completed.***
- Branch Code - Complete only if employer was assigned a Branch Code number.
- Federal Employer Identification Number.
- Business name and address.
- Contact person and phone number.

**Employee's:**

- First name, middle initial, and last name.
- Social Security number.
- Home address.
- Start-of-work date.

### HOW TO COMPLETE THIS FORM:

Please complete the following information in the spaces provided. If you type the information, ignore the boxes and type in UPPER CASE as shown. Do not use dashes, slashes, commas, or periods.

| EMPLOYEE FIRST NAME | MI | EMPLOYEE LAST NAME | | |
|---|---|---|---|---|
| IMOGENE | A | SAMPLE | | |
| SOCIAL SECURITY NUMBER | STREET NUMBER | STREET NAME | | UNIT/APT |
| 000000000 | 1234 | ANY STREET | | 312 |

If handwritten, use CAPITAL LETTERS and print each letter or number in a separate box as shown. Do not use dashes, slashes, commas, or periods.

| EMPLOYEE FIRST NAME | MI | EMPLOYEE LAST NAME | | |
|---|---|---|---|---|
| I M O G E N E | A | S A M P L E | | |
| SOCIAL SECURITY NUMBER | STREET NUMBER | STREET NAME | | UNIT/APT |
| 0 0 0 0 0 0 0 0 0 | 1 2 3 4 | A N Y S T R E E T | | 3 1 2 |

### ADDITIONAL INFORMATION:

If you have any questions concerning the new employee reporting requirement, you may visit our web page at **www.edd.ca.gov/Payroll_Taxes/New_Hire_Reporting.htm**, call the New Employee Registry and Independent Contractor Reporting at 916-657-0529, call the Taxpayer Assistance Center at 888-745-3886, or visit your local Employment Tax Office, which is listed in the *California Employer's Guide,* DE 44, and on our web page at **www.edd.ca.gov/Office_Locator/**.

To obtain additional DE 34 forms:

- Visit our website at **www.edd.ca.gov/Forms.**
- For 25 or more forms, call 916-322-2835.
- For less than 25 forms, call 916-657-0529 or call 888-745-3886.

### HOW TO REPORT:

For a fast, easy, and secure way to report your new employee information, use e-Services for Business. For more information or to enroll, visit **www.edd.ca.gov/e-Services_for_Business**.

To file a paper DE 34 form, complete all of the information on the reverse side of this form and fax it to 916-319-4400 or mail it to:

**EMPLOYMENT DEVELOPMENT DEPARTMENT**
**PO Box 997016, MIC 96**
**West Sacramento, CA 95799-7016**

Employment Development Department
State of California

# REPORT OF INDEPENDENT CONTRACTOR(S)

05420101

*See detailed instructions on reverse side. Please type or print.*

**SERVICE-RECIPIENT** (BUSINESS OR GOVERNMENT ENTITY):

DATE

FEDERAL ID NUMBER

CA EMPLOYER ACCOUNT NUMBER

SOCIAL SECURITY NUMBER

SERVICE-RECIPIENT NAME / BUSINESS NAME

CONTACT PERSON

ADDRESS

PHONE NUMBER

CITY

STATE

ZIP CODE

**SERVICE-PROVIDER** (INDEPENDENT CONTRACTOR):

FIRST NAME

MI

LAST NAME

SOCIAL SECURITY NUMBER

STREET NUMBER

STREET NAME

UNIT/APT

CITY

STATE

ZIP CODE

START DATE OF CONTRACT

M M D D Y Y

AMOUNT OF CONTRACT

, , .

CONTRACT EXPIRATION DATE

M M D D Y Y

CHECK HERE IF CONTRACT IS ONGOING ☐

FIRST NAME

MI

LAST NAME

SOCIAL SECURITY NUMBER

STREET NUMBER

STREET NAME

UNIT/APT

CITY

STATE

ZIP CODE

START DATE OF CONTRACT

M M D D Y Y

AMOUNT OF CONTRACT

, , .

CONTRACT EXPIRATION DATE

M M D D Y Y

CHECK HERE IF CONTRACT IS ONGOING ☐

FIRST NAME

MI

LAST NAME

SOCIAL SECURITY NUMBER

STREET NUMBER

STREET NAME

UNIT/APT

CITY

STATE

ZIP CODE

START DATE OF CONTRACT

M M D D Y Y

AMOUNT OF CONTRACT

, , .

CONTRACT EXPIRATION DATE

M M D D Y Y

CHECK HERE IF CONTRACT IS ONGOING ☐

MAIL TO: Employment Development Department • PO Box 997350, MIC 96 • Sacramento, CA 95899-7350
or Fax to 916-319-4410

## INSTRUCTIONS FOR COMPLETING ALL OF THE ELEMENTS ON THE *REPORT OF INDEPENDENT CONTRACTOR(S)*, DE 542

### WHO MUST REPORT:

Any business or government entity (defined as a "Service-Recipient") that is required to file a federal Form 1099-MISC for service performed by an independent contractor (defined as a "Service-Provider") must report. You must report to the Employment Development Department (EDD) within 20 days of EITHER making payments of $600 or more OR entering into a contract for $600 or more with an independent contractor in any calendar year, whichever is earlier. This information is used to assist state and county agencies in locating parents who are delinquent in their child support obligations.

An independent contractor is further defined as an individual who is not an employee of the business or government entity for California purposes and who receives compensation or executes a contract for services performed for that business or government entity either in or outside of California. For further clarification, request *Information Sheet: Employment Work Status Determination*, DE 231ES. See below for information on how to obtain additional forms.

### YOU ARE REQUIRED TO PROVIDE THE FOLLOWING INFORMATION THAT APPLIES:

**Service-Recipient (Business or Government Entity)**

- Federal Employer Identification Number (FEIN)
- California employer payroll tax account number (if applicable)
- Social Security number
- Service-recipient name/business name, address, and phone number
- Contact person

**Service-Provider (Independent Contractor)**

- First name, middle initial, and last name
- Social Security number (do not use FEIN)
- Address
- Start date of contract (if no contract, date payments equal $600 or more)
- Amount of contract (including cents)
- Contract expiration date or check the box if the contract is ongoing

### HOW TO COMPLETE THIS FORM:

If you use a typewriter or printer, ignore the boxes and type in UPPER CASE as shown. Do not use commas or periods.

| FIRST NAME | MI | LAST NAME |
|---|---|---|
| IMOGENE | A | SAMPLE |

| SOCIAL SECURITY NUMBER | STREET NUMBER | STREET NAME | UNIT / APT. |
|---|---|---|---|
| XXXXXXXXX | 12345 | MAIN STREET | 301 |

If you handwrite this form, print each letter or number in a separate box as shown. Do not use commas or periods.

| FIRST NAME | MI | LAST NAME |
|---|---|---|
| I M O G E N E | A | S A M P L E |

| SOCIAL SECURITY NUMBER | STREET NUMBER | STREET NAME | UNIT / APT. |
|---|---|---|---|
| X X X X X X X X X | 1 2 3 4 5 | M A I N S T R E E T | 3 0 1 |

### ADDITIONAL INFORMATION:

If you have questions concerning the independent contractor reporting requirement, you may visit our web page at **www.edd.ca.gov/Payroll_Taxes/Independent_Contractor_Reporting.htm**, call the New Employee Registry and Independent Contractor Reporting at 916-657-0529, call the Taxpayer Assistance Center at 888-745-3886, or visit your local Employment Tax Office listed in the *California Employer's Guide*, DE 44, and on our web page at **www.edd.ca.gov/Office_Locator/**.

To obtain additional DE 542 forms:

- Visit the EDD website at **www.edd.ca.gov/Forms/**.
- For 25 or more forms, call 916-322-2835.
- For less than 25 forms, call 916-657-0529 or call 888-745-3886.

### HOW TO REPORT:

For a fast, easy, and secure way to report your independent contractor information, use e-Services for Business. For more information or to enroll, visit **www.edd.ca.gov/e-Services_for_Business**.

To file a paper DE 542 form, complete all of the information on the reverse side of this form and fax it to 916-319-4410 or mail it to:

**EMPLOYMENT DEVELOPMENT DEPARTMENT**
**PO Box 997350, MIC 96**
**Sacramento, CA 95899-7350**

SACRAMENTO COUNTY DEPARTMENT OF CHILD
SUPPORT SERVICES
PO BOX 269112
SACRAMENTO CA 95826-9112

08/15/2017

CSE Case Number: 200000001870868
Participant Name:
ROGER RABBIT
SSN: 316-31-3113
DOB: 04/04/1984
Driver License:
Last Known Address:
185 MAIN AVE
SACRAMENTO CA 95838

ABC
1000 MAIN STREET
SACRAMENTO CA 95859

Attention Personnel Department:

California Family Code section 17512 requires employers and labor organizations to provide employment, income and health insurance information about their employees to child support agencies within 30 calendar days upon written request. This written information request is made pursuant to California Family Code section 17512. Please provide the information requested below within 30 calendar days of the date you received this letter.

This office has received information that ROGER RABBIT is working or has worked for your company/ business. Please complete the enclosed form about this person, sign the certification, and return the completed form to the address listed below. **Alternatively, if your personnel records are maintained in such a format that all of the information requested on the enclosed form exists in one or more document(s) which you can print out and attach; you may do so instead of completing the form.** However, **all** of the information must be included. Partial compliance is non-compliance and subject to penalty. You must still sign the certification.

Return requested information to this address:

SACRAMENTO COUNTY DEPARTMENT OF CHILD SUPPORT SERVICES
PO BOX 269112
SACRAMENTO CA 95826-9112

If you have any questions or need additional information, please visit the Employer Resource Center on the web at: http://www.childsup.ca.gov/Employer.aspx or call CustomerConnect at (866) 901-3212. To update your company demographics please do so here: http://www.childsup.ca.gov/Employer/EmployerInformationRequest.aspx. Persons with hearing or speech impairments, please call the TTY number, (866) 399-4096.

Sincerely,

ABE MENDOZA
Child Support Representative

Enclosure

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# WAGE AND INSURANCE VERIFICATION

DCSS 0230 (01/18/15)

CSE Case Number: 200000001870868
Participant Name: ROGER RABBIT
Employer Name: ABC

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

A. Name: ROGER RABBIT

B. Social Security Number: 316-31-3113

C. Date of Birth: 04/04/1984

D. Address: 185 MAIN AVE
SACRAMENTO CA 95838

E. Phone Number: _____

## 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

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 employee has 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.

| 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 | $ |

DS2348483604 DD2636057879

# WAGE AND INSURANCE VERIFICATION

DCSS 0230 (01/18/15)

CSE Case Number: 200000001870868
Participant Name: ROGER RABBIT
Employer Name: ABC

## 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 |
|---|---|---|---|---|
| Insurance Co. Name: | | | | |
| Mailing Address: | | | | |
| | | | | |
| | | | | |
| Phone Number: | | | | |
| Policy Number.: | | | | |
| Effective Date: | | | | |
| Expiration Date: | | | | |

# WAGE AND INSURANCE VERIFICATION

DCSS 0230 (01/18/15)

CSE Case Number: 200000001870868
Participant Name: ROGER RABBIT
Employer Name: ABC

## 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

| Telephone Number | Fax Number | Email Address |
|---|---|---|
| | | |

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SACRAMENTO COUNTY DEPARTMENT OF CHILD
SUPPORT SERVICES
PO BOX 269112
SACRAMENTO CA 95826-9112

08/15/2017

ABC
1000 MAIN STREET
SACRAMENTO CA 95859

Re: RABBIT, ROGER

SSN: 316-31-3113
DOB: 04/04/1984
CSE Case Number:
200000001870868
Participant Number:
300000005018210

Attention Payroll/Benefits Department:

Subject: Income Withholding for Support (IWO) OMB 0970-0154

Enclosed is an Income Withholding for Support (IWO) OMB 0970-0154 package. This package requires your immediate attention.

Legal Requirements

- The IWO requires you as an employer to deduct a portion of the employee's earnings as defined by Family Code (FC) section 5206 and forward this sum for payment on a support obligation. You must deduct earnings for support up to the maximum amount authorized by law for situations in which the earnings subject to withholding are insufficient to satisfy all support obligations. Instructions for handling deductions are included as part of the IWO. You may deduct a fee of $1.50 from the employee's earnings for each payment. If the enclosed is an amended IWO, you will only receive documents for the case(s) which impact your employee.

- FC section 17512 also requires employers to report all earnings as defined by FC 5206, including wages, salary bonus, commission, benefits and any other payments or credits due or becoming due regardless of source.

- Report any bonus or other lump sum payments prior to payout by contacting the Department of Child Support Services (DCSS) at (916) 464-6640 or via email at ***lumpsumresponseteam@dcss.ca.gov.*** To report bonus payments through the federal Office of Child Support Enforcement (OCSE) employers may register at ***www.acf.hhs.gov/programs/css/employers/bonus-lump-sum-payments*** or through OCSE via email at ***ACFEmployerServices@acf.hhs.gov.***

- The IWO takes effect immediately and will remain in effect until further notice. You are required by law to comply with these orders and notices, otherwise you may be subject to sanctions or penalties including, but not limited to, those available under FC sections 5241 and 3768. These sections state that willful failure to comply may result in liability for the amount of support not withheld, including interest.

- These sections also state that such conduct by an employer may be punishable as contempt of court under California Code of Civil Procedure section 1218.

- Pursuant to California FC section 17309.5, if an employer pays taxes electronically to the Franchise Tax Board or the Employment Development Department, then child support payments are required to be sent to the State Disbursement Unit (SDU) using Electronic Funds Transfer. To remit payments electronically visit the California SDU at ***www.childsup.ca.gov/Payments/StateDisbursementUnit(sdu).aspx***.

Forms

If you do business in the State of California, California FC section 5234 requires you to give the employee the following enclosed forms within 10 days of receipt of this package:

- Income Withholding for Support (OMB 0970-0154)
  If you wish to receive the IWO form electronically in the future, visit DCSS at ***www.childsup.ca.gov/Employer/ElectronicIncomeWithholdingOrders(e-iwo).aspx***.

- Request for Hearing Regarding Earnings Assignment (FL-450)

The following employer forms are located at ***www.childsup.ca.gov/employer.aspx***:

- Termination of Benefits/Employment Notice (DCSS 0114)
  Complete and return this form to the Local Child Support Agency (LCSA) if the employee leaves your employment or has a lapse in health coverage.

- Employee Status Report (DCSS 0522)
  Please complete and return this form to the LCSA.

If you have questions or need additional information on obtaining or downloading forms, please visit the Employer Resource Center at ***www.childsup.ca.gov/Employer.aspx*** or call Customer Connect at (866) 901-3212. Please update your company demographics at ***www.childsup.ca.gov/Employer/EmployerInformationRequest.aspx***. Persons with hearing or speech impairments, please call the TTY number at (866) 399-4096.

Sincerely,

ABE MENDOZA
Child Support Representative

Enclosures

# INCOME WITHHOLDING FOR SUPPORT

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

**Date:** 08/15/2017

☒ 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/programs/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 order must be attached.

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

Remittance ID (include w/payment) 200000001870868
Order ID FL-9874
CSE Agency Case ID 200000001870868

ABC
Employer/Income Withholder's Name

1000 MAIN STREET
Employer/Income Withholder's Address

SACRAMENTO CA 95859

Employer/Income Withholder's FEIN 123456788

RE: RABBIT, ROGER
Employee/Obligor's Name (Last, First, Middle)

316-31-3113
Employee/Obligor's Social Security Number

OGRE, FIONA
Custodial Party/Obligee's Name (Last, First, Middle)

| Child(ren)'s Name(s) (Last, First, Middle) | Child(ren)'s Birth Date(s) |
|---|---|
| RABBIT, PETER | 02/02/2010 |

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

$ 958.00 Per MONTH current child support
$ 0.00 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 **$** 958.00 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:

$ 221.07 per weekly pay period
$ 479.00 per semimonthly pay period (twice a month)
$ 442.15 per biweekly pay period (every two weeks)
$ 958.00 per monthly pay period
$ _____ **Lump Sum Payment:** Do not stop any existing IWO unless you receive a termination order.

Document Tracking ID _____

OMB 0970-0154

Employer's Name: ABC Employer FEIN: 123456788

Employee/Obligor's Name: RABBIT, ROGER SSN: 316-31-3113

CSE Agency Case Identifier: 200000001870868 Order Identifier: FL-9874

***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 08/15/2017 .Send payment within 7 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 50 % of disposable income. If the obligor is a non-employee, obtain withholding limits from Supplemental Information on page 3. If the employee/obligor's principal place of employment is not CALIFORNIA (State/Tribe), obtain withholding limitations, time requirements, and any allowable employer fees at **www.acf.hhs.gov/programs/css/resource/state-income-withholding-contacts-and-program-information** for the employee/obligor's principal place of employment.

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

Include the ***Remittance ID*** **with the payment** and if necessary this FIPS code: 0600099

**Remit payment to** CALIFORNIA STATE DISBURSEMENT UNIT (SDU/Tribal Order Payee)
at PO BOX 989067, WEST SACRAMENTO CA 95798-9067 (SDU/Tribal Payee Address)

☐ **Return to Sender [Completed by Employer/Income Withholder].** Payment must be directed to an SDU in accordance with 42 USC §666(b)(5) and (b)(6) or Tribal Payee (see Payments to SDU below). If payment is not directed to an SDU/Tribal Payee or this IWO is not regular on its face, you *must* check this box and return the IWO to the sender.

Signature of Judge/Issuing Official (if Required by State or Tribal Law):
Print Name of Judge/Issuing Official: ABE MENDOZA
Title of Judge/Issuing Official: Child Support Representative
Date of Signature:

If the employee/obligor works in a state or for a tribe that is different from the state or tribe that issued this order, a copy of this IWO must be provided to the employee/obligor.
☒If checked, the employer/income withholder must provide a copy of this form to the employee/obligor.

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## ADDITIONAL INFORMATION FOR EMPLOYERS/INCOME WITHHOLDERS

State-specific contact and withholding information can be found on the Federal Employer Services website located at **www.acf.hhs.gov/programs/css/resource/state-income-withholding-contacts-and-program-information.**

**Priority:** Withholding for support has priority over any other legal process under State law against the same income (42 USC §666(b)(7)). If a federal tax levy is in effect, please notify the sender.

**Combining Payments:** When remitting payments to an SDU or tribal CSE agency, you may combine withheld amounts from more than one employee/obligor's income in a single payment. You must, however, separately identify each employee/obligor's portion of the payment.

**Payments To SDU:** You must send child support payments payable by income withholding to the appropriate SDU or to a tribal CSE agency. If this IWO instructs you to send a payment to an entity other than an SDU (e.g., payable to the custodial party, court, or attorney), you must check the box above and return this notice to the sender. Exception: If this IWO was sent by a court, attorney, or private individual/entity and the initial order was entered before January 1, 1994 or the order was issued by a tribal CSE agency, you must follow the "Remit payment to" instructions on this form.

**Reporting the Pay Date:** You must report the pay date when sending the payment. The pay date is the date on which the amount was withheld from the employee/obligor's wages. You must comply with the law of the state (or tribal law if applicable) of the employee/obligor's principal place of employment regarding time periods within which you must implement the withholding and forward the support payments.

**Multiple IWOs:** If there is more than one IWO against this employee/obligor and you are unable to fully honor all IWOs due to federal, state, or tribal withholding limits, you must honor all IWOs to the greatest extent possible, giving priority to current support before payment of any past-due support. Follow the state or tribal law/procedure of the employee/obligor's principal place of employment to determine the appropriate allocation method.

OMB Expiration Date - 07/31/2017. The OMB Expiration Date has no bearing on the termination date of the IWO; it identifies the version of the form currently in use.

Employer's Name: ABC Employer FEIN: 123456788

Employee/Obligor's Name: RABBIT, ROGER SSN: 316-31-3113

CSE Agency Case Identifier: 200000001870868 Order Identifier: FL-9874

**Lump Sum Payments:** You may be required to notify a state or tribal CSE agency of upcoming lump sum payments to this employee/obligor such as bonuses, commissions, or severance pay. Contact the sender to determine if you are required to report and/or withhold lump sum payments.

**Liability:** If you have any doubts about the validity of this IWO, contact the sender. If you fail to withhold income from the employee/obligor's income as the IWO directs, you are liable for both the accumulated amount you should have withheld and any penalties set by state or tribal law/procedure.

See Contact Information on page 4.

**Anti-discrimination:** You are subject to a fine determined under state or tribal law for discharging an employee/obligor from employment, refusing to employ, or taking disciplinary action against an employee/obligor because of this IWO.

**Withholding Limits:** You may not withhold more than the lesser of: 1) the amounts allowed by the Federal Consumer Credit Protection Act (CCPA) (15 USC §1673(b)); or 2) the amounts allowed by the state of the employee/obligor's principal place of employment or tribal law if a tribal order (see *Remittance Information*). Disposable income is the net income after mandatory deductions such as: state, federal, local taxes; Social Security taxes; statutory pension contributions; and Medicare taxes. The federal limit is 50% of the disposable income if the obligor is supporting another family and 60% of the disposable income if the obligor is not supporting another family. However, those limits increase 5% --to 55% and 65% --if the arrears are greater than 12 weeks. If permitted by the state or tribe, you may deduct a fee for administrative costs. The combined support amount and fee may not exceed the limit indicated in this section.

For tribal orders, you may not withhold more than the amounts allowed under the law of the issuing tribe. For tribal employers/income withholders who receive a state IWO, you may not withhold more than the limit set by tribal law.

Depending upon applicable state or tribal law, you may need to consider amounts paid for health care premiums in determining disposable income and applying appropriate withholding limits.

**Arrears greater than 12 weeks?** If the *Order Information* does not indicate that the arrears are greater than 12 weeks, then the employer should calculate the CCPA limit using the lower percentage.

**Supplemental Information:**

To update your company's demographics, visit: **http://www.childsup.ca.gov/Employer/EmployerInformationRequest.aspx** or visit the Employer Resource Center at: **http://www.childsup.ca.gov/Employer.aspx**

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

Employer's Name: ABC Employer FEIN: 123456788

Employee/Obligor's Name: RABBIT, ROGER SSN: 316-31-3113

CSE Agency Case Identifier: 200000001870868 Order Identifier: FL-9874

**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 phone 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 phone: (866) 901-3212, by fax: (916) 875-7499, by e-mail or website:

http://www.childsup-connect.ca.gov

Send termination/income status notice and other correspondence to: SACRAMENTO

PO BOX 269112, SACRAMENTO CA 95826-9112 (issuer address).

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

by phone: (866) 901-3212, by fax: (916) 875-7499, by e-mail or website:

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The Paperwork Reduction Act of 1995

This information collection and associated responses are conducted in accordance with 45 CFR 303.100 of the Child Support Enforcement Program. This form is designed to provide uniformity and standardization. Public reporting burden for this collection of information is estimated to average 5 minutes per response for Non-IV-D CPs; 2 minutes per response for employers; 3 seconds for e-IWO employers, including the time for 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.

# INCOME WITHHOLDING FOR SUPPORT

☒ **ORIGINAL INCOME WITHHOLDING ORDER/NOTICE FOR SUPPORT (IWO)**
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State/Tribe/Territory CALIFORNIA
City/County/Dist./Tribe SACRAMENTO
Private Individual/Entity

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Employer/Income Withholder's Name

1000 MAIN STREET
Employer/Income Withholder's Address

SACRAMENTO CA 95859

Employer/Income Withholder's FEIN 123456788

RE: RABBIT, ROGER
Employee/Obligor's Name (Last, First, Middle)

316-31-3113
Employee/Obligor's Social Security Number

OGRE, FIONA
Custodial Party/Obligee's Name (Last, First, Middle)

| Child(ren)'s Name(s) (Last, First, Middle) | Child(ren)'s Birth Date(s) |
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| RABBIT, PETER | 02/02/2010 |

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for a **Total Amount to Withhold** of **$** 958.00 per MONTH.

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Document Tracking ID _____

OMB 0970-0154

Employer's Name: ABC Employer FEIN: 123456788

Employee/Obligor's Name: RABBIT, ROGER SSN: 316-31-3113

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Print Name of Judge/Issuing Official: ABE MENDOZA
Title of Judge/Issuing Official: Child Support Representative
Date of Signature:

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OMB Expiration Date - 07/31/2017. The OMB Expiration Date has no bearing on the termination date of the IWO; it identifies the version of the form currently in use.

Employer's Name: ABC Employer FEIN: 123456788

Employee/Obligor's Name: RABBIT, ROGER SSN: 316-31-3113

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**Liability:** If you have any doubts about the validity of this IWO, contact the sender. If you fail to withhold income from the employee/obligor's income as the IWO directs, you are liable for both the accumulated amount you should have withheld and any penalties set by state or tribal law/procedure.

See Contact Information on page 4.

**Anti-discrimination:** You are subject to a fine determined under state or tribal law for discharging an employee/obligor from employment, refusing to employ, or taking disciplinary action against an employee/obligor because of this IWO.

**Withholding Limits:** You may not withhold more than the lesser of: 1) the amounts allowed by the Federal Consumer Credit Protection Act (CCPA) (15 USC §1673(b)); or 2) the amounts allowed by the state of the employee/obligor's principal place of employment or tribal law if a tribal order (see *Remittance Information*). Disposable income is the net income after mandatory deductions such as: state, federal, local taxes; Social Security taxes; statutory pension contributions; and Medicare taxes. The federal limit is 50% of the disposable income if the obligor is supporting another family and 60% of the disposable income if the obligor is not supporting another family. However, those limits increase 5% --to 55% and 65% --if the arrears are greater than 12 weeks. If permitted by the state or tribe, you may deduct a fee for administrative costs. The combined support amount and fee may not exceed the limit indicated in this section.

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**Supplemental Information:**

To update your company's demographics, visit: **http://www.childsup.ca.gov/Employer/EmployerInformationRequest.aspx** or visit the Employer Resource Center at: **http://www.childsup.ca.gov/Employer.aspx**

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

Employer's Name: ABC Employer FEIN: 123456788

Employee/Obligor's Name: RABBIT, ROGER SSN: 316-31-3113

CSE Agency Case Identifier: 200000001870868 Order Identifier: FL-9874

**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 phone 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 phone: (866) 901-3212, by fax: (916) 875-7499, by e-mail or website:

http://www.childsup-connect.ca.gov

Send termination/income status notice and other correspondence to: SACRAMENTO

PO BOX 269112, SACRAMENTO CA 95826-9112 (issuer address).

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

by phone: (866) 901-3212, by fax: (916) 875-7499, by e-mail or website:

_____

The Paperwork Reduction Act of 1995

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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.

| ATTORNEY OR PARTY WITHOUT ATTORNEY *(Name, State Bar number, and address)*: | *FOR COURT USE ONLY* |
|---|---|
| 200000001870868<br>TELEPHONE NO.: FAX NO. *(Optional)*:<br>E-MAIL ADDRESS *(Optional)*:<br>ATTORNEY FOR *(Name)*: | |
| **SUPERIOR COURT OF CALIFORNIA, COUNTY OF SACRAMENTO**<br>STREET ADDRESS: 3341 POWER INN RD<br>MAILING ADDRESS: 3341 POWER INN RD<br>CITY AND ZIP CODE: SACRAMENTO 95826-3835<br>BRANCH NAME: WILLIAM R. RIDGEWAY FAMILY RELATIONS COURTHOUSE | |
| PETITIONER/PLAINTIFF: COUNTY OF SACRAMENTO<br>RESPONDENT/DEFENDANT: ROGER RABBIT<br>OTHER PARENT: FIONA OGRE | |
| **REQUEST FOR HEARING REGARDING EARNINGS ASSIGNMENT** | CASE NUMBER:<br>FL-9874 |

**NOTICE: Complete and file this form with the court clerk to request a hearing *only* if you object to the *Income Withholding for Support* (form FL-195/OMB0970-0154) or *Earnings Assignment Order for Spousal or Partner Support* (form FL-435). This form may not be used to modify your current child support amount. (See page 2 of form FL-192, *Information Sheet on Changing a Child Support Order.*) Page 3 of this form is instructional only and does not need to be delivered to the court.**

1. A hearing on this application will be held as follows *(see instructions for getting a hearing date on page 3)*:

   a. Date: Time: ☐ Dept.: ☐ Div.: ☐ Room:

   b. The address of the court is: ☐ same as noted above ☐ other *(specify)*:

2. ☐ I request that service of the *Earnings Assignment Order for Spousal or Partner Support* (form FL-435) or *Income Withholding for Support* (form FL-195/OMB0970-0154) be quashed (set aside) because

   a. ☐ I am not the obligor named in the earnings assignment.

   b. ☐ There is good cause to recall the earnings assignment because **all** of the following conditions exist:

      (1) Recalling the earnings assignment would be in the best interest of the children for whom I am ordered to pay support *(state reasons)*:

      (2) I have paid court-ordered support fully and on time for the last 12 months without either an earnings assignment or another mandatory collection process.

      (3) I do not owe any arrearage (back support).

      (4) Service of the earnings assignment would cause extraordinary hardship for me, as follows *(state reasons; you must prove these reasons at any hearing on this application by clear and convincing evidence)*:

   c. ☐ The other parent and I have a written agreement that allows the support order to be paid by an alternative method. A copy of the agreement is attached. **(NOTE: If the support obligation is paid to the local child support agency, this agreement must be signed by a representative of that agency.)**





| PETITIONER/PLAINTIFF: COUNTY OF SACRAMENTO<br>RESPONDENT/DEFENDANT: ROGER RABBIT<br>OTHER PARENT: FIONA OGRE | CASE NUMBER:<br>FL-9874 |
|---|---|

3. ☐ I request that the earnings assignment be modified because
   a. ☐ the total amount of arrearages claimed as owing is incorrect. *(Check one or more of the following reasons.)*
      (1) ☐ I did not receive credit for all of the payments I have made. *(Check (a), (b), or both.)*
         (a) ☐ I have attached my statement of the payment history, which includes a monthly breakdown of amounts ordered and amounts paid.
         (b) ☐ I made the following payments that were not credited *(for each payment, specify the date, the amount, and the name of the person or agency paid):*

      (2) ☐ Child support has terminated *(specify name of child, child's date of birth, date of termination, and reason support was terminated):*

      (3) ☐ Other *(specify):*

   b. ☐ the monthly payment specified in the earnings assignment is more than half of my total net income each month from all sources.
   c. ☐ the monthly arrearage payment stated in the earnings assignment creates an undue hardship because *(describe the hardship and state the amount you are able to pay on your arrearage):*

**(NOTE: If you want to change the amount of money being deducted for arrearage because it creates a hardship, please attach a completed *Financial Statement (Simplified)* (form FL-155) or *Income and Expense Declaration* (form FL-150).)**

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

Date:

(TYPE OR PRINT NAME OF PERSON REQUESTING HEARING) (SIGNATURE OF PERSON REQUESTING HEARING)

## CLERK'S CERTIFICATE OF MAILING

I certify that I am not a party to this action and that a true copy of the *Request for Hearing Regarding Earnings Assignment* (form FL-450) was mailed, with postage fully prepaid, in a sealed envelope addressed as shown below, and that the request was mailed at *(place)*: on *(date)*:

Date: Clerk, by _____, Deputy

# INFORMATION SHEET AND INSTRUCTIONS FOR REQUEST FOR HEARING REGARDING EARNINGS ASSIGNMENT

**(Do *not* deliver this information sheet to the court clerk.)**

Please follow these instructions to complete the *Request for Hearing Regarding Earnings Assignment* (form FL-450) if you do not have an attorney representing you. Your attorney, if you have one, should complete this form. You must file the completed *Request for Hearing* form and its attachments with the court clerk **within 10 days** after the date your employer gave you a copy of *Earnings Assignment Order for Spousal or Partner Support* (form FL-435) or an *Income Withholding for Support* (form FL-195/ OMB0970-0154). The address of the court clerk is the same as the one shown for the superior court on the earnings assignment order. You may have to pay a filing fee. If you cannot afford to pay the filing fee, the court may waive it, but you will have to fill out some forms first. For more information about the filing fee and waiver of the filing fee, contact the court clerk or the family law facilitator in your county.

**(TYPE OR PRINT IN INK)**

**Front page, first box, top of form, left side:** Print your name, address, and telephone number in this box if they are not already there.

**Item 1.** **a-b.** You must contact the court clerk's office and ask that a hearing date be set for this motion. The court clerk will give you the information you need to complete this section.

**Item 2.** Check this box if you want the court to stop the local child support agency or the other parent from collecting any support from your earnings. If you check this box, you must check the box for either a, b, or c beneath it.

- **a.** Check this box if you are not the person required to pay support in the earnings assignment.
- **b.** Check this box if you believe that there is "good cause" to recall the earnings assignment. **Note**: The court must find that **all** of the conditions listed in item 2b exist in order for good cause to apply.
- **c.** Check this box if you and the other parent have a written agreement that allows you to pay the support another way. **You must attach a copy of the agreement,** which must be signed by both the other parent and a representative of the local child support agency if payments are made to a county office.

**Item 3.** Check this box if you want to change the earnings assignment. If you check this box, you must check the box for either a, b, or c beneath it.

- **a.** Check this box if the total arrearages listed in item 9 on the earnings assignment order are wrong. If you check this box, you must check one or more of (1), (2), or (3). You must attach the original of your statement of arrearages. Keep one copy for yourself.
  - **(1)** Check this box if you believe that the amount of arrearages listed on the earnings assignment order does not give you credit for all the payments you have made. If you check this box, you must check one or both of the boxes beneath it.
    - **(a)** Check this box if you are attaching your own statement of arrearages. This statement must include a monthly listing of what you were ordered to pay and what you actually paid.
    - **(b)** Check this box if you wish to list any payments that you believe were not included in the arrearages amount. For each payment you must list the date you paid it, the amount paid, and the person or agency (such as the local child support agency) to whom you made the payment. Bring to the hearing proof of any payment that is in dispute.
  - **(2)** Check this box if the child support for any of the children in the case has been terminated (ended). If you check this box, you must list the following information for each child:
    - The name and birthdate of each child.
    - The date the child support order was terminated.
    - The reason child support was terminated.
  - **(3)** Check this box if there is another reason you believe the amount of arrearages is incorrect. You must explain the reasons in detail.
- **b.** Check this box if the total monthly payment shown in item 1 of the earnings assignment order is more than half of your monthly net income.
- **c.** Check this box if the total monthly payment shown in item 1 of the earnings assignment order causes you a serious hardship. You must write the reasons for the hardship in this space.

You must date this *Request for Hearing* form, print your name, and sign the form under penalty of perjury. You must also complete the certificate of mailing at the bottom of page 2 of the form by printing the name and address of the other parties in brackets and providing a stamped envelope addressed to each of the parties. When you sign this *Request for Hearing* form, you are stating that the information you have provided is true and correct. After you file the request, the court clerk will notify you by mail of the date, time, and location of the hearing.

**You must file your request within 10 days of receiving the *Earnings Assignment Order for Spousal or Partner Support* or the *Income Withholding for Support* from your employer. You may file your request in person at the clerk's office or mail it to the clerk. In either event, it must be received by the clerk within the 10-day period.**

If you need additional assistance with this form, contact an attorney or the family law facilitator in your county. Your family law facilitator can help you, for free, with any questions you have about the above information. For more information on finding a lawyer or family law facilitator, see the California Courts Online Self-Help Center at *www.courtinfo.ca.gov/selfhelp/*.

**NOTICE: Use form FL-450 to request a hearing only if you object to the *Income Withholding for Support* (form FL-195/OMB0970-0154) or *Earnings Assignment Order for Spousal or Partner Support* (form FL-435). This form will *not* modify your current support amount. (See page 2 of form FL-192, *Information Sheet on Changing a Child Support Order*).**

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# TERMINATION OF BENEFITS / EMPLOYMENT NOTICE

DCSS 0114 (08/21/2016)

DATE:

EMPLOYER:

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<br>☐ Temporary Lapse - date coverage is to resume _____ DATE ☐ Permanent Termination | |
|---|---|---|
| COBRA HEALTH INSURANCE AVAILABLE?<br>☐ NO ☐ YES, coverage thru: _____ DATE | | |
| DATE OF TERMINATION - EMPLOYMENT | REASON FOR TERMINATION | SUBJECT TO REHIRE?<br>☐ 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

TITLE

CSE Case Number:
Noncustodial Parent:

Court Case Number:
Employer Name:

Employer Address:

Attention Payroll/Benefits Department:

The Income Withholding Order/Notice for Support (IWO) is to remain in effect until further notice. Please complete the information requested below and return the Employee Status Report to the address listed on the IWO within 10 days of the date on this letter:

1. ☐ We received the IWO regarding the employee named above on _____. (Date)
2. ☐ The employee named above is presently employed. The withholding will begin on _____. (Date)
3. ☐ Our payroll is issued: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Twice a month on _____. (Date)
4. ☐ The salary of the employee named above is being direct deposited _____. (Name of Financial Institution)
5. ☐ On _____, the above employee: ☐ was terminated ☐ voluntarily left our employment (Date)
   ☐ is presently on lay-off status and will return to work on _____. (Estimated return date)
6. ☐ The employee named above is currently employed at _____ (Company name, if known)
   _____. (Address, if known)
7. ☐ Is Dependent Health Insurance Coverage Provided: ☐ Yes ☐ No

If you prefer you may call our office at 1-866-901-3212.

I declare under penalty of perjury under the laws of the State of California that the foregoing information is true and correct. Executed on _____ (Date) at _____ (City), _____ (State).

_____ (Signature)

_____ (Print Name)

_____ (Job Title)

_____ (Phone Number)

_____ (Fax Number)

# 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.***

## 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

The Policy covers the following: (Check all that apply)

☐ Doctor Visits ☐ Medicare Supplemental ☐ Specific Illness ☐ Prescription Drugs

☐ Long Term Care ☐ Hospital Stays ☐ Hospital Outpatient *(i.e., lab work, physical therapy)* ☐ Other (Specify):

**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:**

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

## SECTION II: OTHER PARENT'S INSURANCE

**HEALTH INSURANCE:**
Does the other parent currently provide Health Insurance coverage for the child(ren) or you? ☐ Yes ☐ No
If Yes, please complete the following information.

Health Insurance Company

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

City State Zip Code

**DENTAL INSURANCE:**
Does the other parent currently provide Dental Insurance coverage for the child(ren) or you? ☐ Yes ☐ No
If Yes, please complete the following information.
Dental Insurance Company

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

City State Zip Code

**VISION INSURANCE:**
Does the other parent currently provide Vision Insurance coverage for the child(ren) or you? ☐ Yes ☐ No
If Yes, please complete the following information.
Vision Insurance Company

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

City State Zip Code

## 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

SACRAMENTO COUNTY DEPARTMENT OF CHILD
SUPPORT SERVICES
PO BOX 269112
SACRAMENTO CA 95826-9112


08/15/2017

ABC
1000 MAIN STREET
SACRAMENTO CA 95859

Re: ROGER RABBIT

SSN: 316-31-3113
DOB: 04/04/1984
CSE Case Number:
200000001870868
Participant Number:
300000005018210

Attention Benefits Department:

Subject: National Medical Support Notice (NMSN) OMB 0970-0222

Enclosed is a copy of the National Medical Support Notice (NMSN) OMB 0970-0222 package for each of the employee's cases. This package requires your immediate attention.

The NMSN requires you to enroll the child(ren) listed in the notice into a group health insurance plan that is available through employment with your company even if the employee refuses to cooperate in doing so. This includes deducting the appropriate cost for the coverage from the earnings of your employee. If coverage is provided, you must complete and return the Health Insurance Information form DCSS 0054 to the SACRAMENTO County Department of Child Support Services. The NMSN commences immediately and will remain in effect until further notice.

Legal Requirements

- As an employer, you are required by law to comply with this notice, otherwise you may be subject to sanctions or penalties including, but not limited to, those available under Family Code (FC) section 3768. This section specifically states that willful failure to comply may result in liability for the amount of health care services incurred that would otherwise have been covered under the health insurance plan. This section also states that such conduct by an employer may be punishable as contempt of court under California Code of Civil Procedure section 1218.

- Additional instructions, including the priority of withholding, are included as part of the NMSN. If the employee leaves or terminates employment, you must complete and return the Termination of Benefits/Employment Notice DCSS 0114 to the SACRAMENTO County Department of Child Support Services. You must also provide the employee's last known address and the address of the new employer, if known.



If you do business in the State of California, FC sections 3764, 3773 and 5234 require you to give the employee the following forms within 10 days receipt of this package.

- A copy of each NMSN Part A (OMB 0970-0222)
  The information on the Custodial Parent and Child(ren) contained on this notice is confidential and should not be shared or disclosed to the employee.
- Statement of Obligor's Rights and Procedures Regarding a National Medical Support Notice (NMSN) or Health Insurance Assignment Order (DCSS 0361)
- Request and Notice of Hearing Regarding Health Insurance Assignment (FL-478)
- Information Sheet and Instructions for Request and Notice of Hearing Regarding Health Insurance Assignment (FL-478-INFO)

Forms

The following employer forms are located at ***www.childsup.ca.gov/Employer.aspx***:

- Health Insurance Information (DCSS 0054)
- Termination of Benefits/Employment Notice (DCSS 0114)
  Complete and return this form to the Local Child Support Agency if the employee leaves your employment or has a lapse in health coverage.
- Request and Notice of Hearing Regarding Health Insurance Assignment (FL-478)
- Information Sheet and Instructions for Request and Notice of Hearing Regarding Health Insurance Assignment (FL-478-INFO)

If you have questions or need information on obtaining or downloading forms, please visit the Employer Resource Center at ***www.childsup.ca.gov/Employer.aspx*** or call Customer Connect at (866) 901-3212. Please update your company demographics at ***www.childsup.ca.gov/Employer/EmployerInformationRequest.aspx***. Persons with hearing or speech impairments, please call the TTY number at (866) 399-4096.

Sincerely,

ABE MENDOZA
Child Support Representative

Enclosures

## NATIONAL MEDICAL SUPPORT NOTICE - PART A
## NOTICE TO WITHHOLD FOR HEALTH CARE COVERAGE

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: SACRAMENTO DCSS<br>Issuing Agency Address:<br>PO BOX 269112<br>SACRAMENTO CA 95826-9112<br><br>Notice Date: 08/15/2017<br>CSE Agency Case Identifier: 200000001870868<br>Telephone Number: (866) 901-3212<br>FAX Number: (916) 875-7499 | Court or Administrative Authority:<br>SUPERIOR COURT OF CALIFORNIA, COUNTY OF SACRAMENTO<br>Order Date: 07/28/2017<br>Order Identifier: FL-9874<br>Document Tracking Identifier:<br>Employer web site:<br>See NMSN Instructions: http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form |

RE:

| | |
|---|---|
| 123456788<br>Employer/Withholder's Federal EIN Number | RABBIT, ROGER<br>Employee's Name (Last, First, MI) |
| ABC<br>Employer/Withholder's Name | 316-31-3113<br>Employee's Social Security Number |
| 1000 MAIN STREET<br>SACRAMENTO, CA 95859<br>Employer/Withholder's Address | 185 MAIN AVE<br>SACRAMENTO, CA 95838<br>Employee's Mailing Address |
| Custodial Parent's Name (Last, First, MI) | SACRAMENTO COUNTY DEPARTMENT OF CHILD SUPPORT SERVICES<br>Substituted Official/Agency Name |
| Custodial Parent's Mailing Address | PO BOX 269112<br>SACRAMENTO CA 95826-9112<br>Substituted Official/Agency Address<br>(Required if Custodial Parent's mailing address is left blank) |
| Child(ren)'s Mailing Address (if different from Custodial Parent's) | |
| Name and Telephone of a Representative of the Child(ren) | Mailing Address of a Representative of the Child(ren) |

| Child(ren)'s Name(s) | Gender | DOB | SSN | Child(ren)'s Name(s) | Gender | DOB | SSN |
|---|---|---|---|---|---|---|---|
| PETER RABBIT | M | 02/02/2010 | | | | | |
| | | | | | | | |
| | | | | | | | |

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.**

## LIMITATIONS ON WITHHOLDING

The total amount withheld for both cash and medical support cannot exceed 50 % of the employee's aggregate disposable weekly earnings. The employer may not withhold more under this National Medical Support Notice than the lesser of:

1. The amounts allowed by the Federal Consumer Credit Protection Act (15 U.S.C., section 1673(b));

2. The amounts allowed by the State of the employee's principal place of employment; or

3. The amounts allowed for health insurance premiums by the child support order, as indicated here: _____.

The Federal limit applies to the aggregate disposable weekly earnings (ADWE). ADWE is the net income left after making mandatory deductions such as State, Federal, local taxes; Social Security taxes; and Medicare taxes. As required under section 2.b.2 of the Employer Responsibilities on page 4, complete item 5 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholdings.

## PRIORITY OF WITHHOLDING

If withholding is required for employee contributions to one or more plans under this notice and for a support obligation under a separate notice and available funds are insufficient for withholding for both cash and medical support contributions, the employer must withhold amounts for purposes of cash support and medical support contributions in accordance with the law, if any, of the State of the employee's principal place of employment requiring prioritization between cash and medical support, as described here:
1) current child, family, and/or spousal support; 2) health insurance premiums and/or medical support; 3) amounts ordered for payments on arrears; and 4) any remaining court ordered amounts.
As required under section 2.b.2 of the Employer Responsibilities on page 4, complete item 5 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholdings.

## 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 to their employment.

☐ 3. The employee is among a class of employees (for example, part-time 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: _____

FAX Number: _____
Telephone Number: _____

Employer Name: ABC
Employer Representative Name/Title: _____

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

Employee Name: ROGER RABBIT
300000005018210

Date: _____

## INSTRUCTIONS TO EMPLOYER

This document serves as legal notice that the employee identified on this National Medical Support Notice is obligated by a court or administrative child support order to provide health care coverage for the child(ren) identified on this Notice. This National Medical Support Notice replaces any Medical Support Notice that the Issuing Agency has previously served on you with respect to the employee and the children listed on this Notice.

The document consists of **Part A - Notice to Withhold for Health Care Coverage** for the employer to withhold any employee contributions required by the group health plan(s) in which the child(ren) is/are enrolled; and **Part B - Medical Support Notice to the Plan Administrator**, which **must** be forwarded to the Administrator of each group health plan identified by the employer to enroll the eligible child(ren), or completed by the employer, if the employer serves as the health Plan Administrator.

An employer receiving this legal Notice is required to complete and return **Part A**. If group health coverage is not available to the employee named herein, or the employee was never or is no longer employed, the employer is still required to complete **Part A - Employer Response** and return it to the Issuing Agency with the appropriate response checked. If you, the employer, provide the health care benefits to the employee, forward **Part B - Plan Administrator Response** to the health Plan Administrator of your organization. If the employee's health care benefits are administered through another organization, including a labor union, forward Part B of the Notice to the labor union or other organization acting as the Plan Administrator for completion. If the employee has already enrolled the child(ren) in health care coverage, the employer must forward Part B to the Plan Administrator for completion and submittal to the Issuing Agency.

Keep a copy of **Part A** as it may be used to notify the Issuing Agency if the employee separates from service for any reason including retirement or termination.

### EMPLOYER RESPONSIBILITIES

1. If the individual named in this Notice is not your employee, or if the family health care coverage is not available, please complete item 1, 2, 3, 4 or 5 of the Employer Response as appropriate, and return it to the Issuing Agency. NO OTHER ACTION IS NECESSARY.

2. If family health care coverage is available for which the child(ren) identified above may be eligible, you are required to:

   a. Transfer, not later than 20 business days after the date of this Notice, a copy of **Part B - Medical Support Notice to the Plan Administrator** to the Administrator of each appropriate group health plan for which the child(ren) may be eligible, complete item 7, and

   b. Upon notification from the Plan Administrator(s) that the child(ren) is/are enrolled, either

      1) withhold from the employee's income any employee contributions required under each group health plan, in accordance with the applicable law of the employee's principal place of employment and transfer employee contributions to the appropriate plan(s), or

      2) complete item 5 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholding.

   c. If the Plan Administrator notifies you that the employee is subject to a waiting period that expires more than 90 days from the date of its receipt of **Part B** of this Notice, or whose duration is determined by a measure other than the passage of time (for example, the completion of a certain number of hours worked), complete item 6 of the Employer Response to notify the Issuing Agency of the enrollment timeframe and notify the Plan Administrator when the employee is eligible to enroll in the plan and that this Notice requires the enrollment of the child(ren) named in the Notice in the plan.

## DURATION OF WITHHOLDING

The child(ren) shall be treated as dependents under the terms of the plan. Coverage of a child as a dependent will end when conditions for eligibility for coverage under terms of the plan no longer apply. However, the continuation coverage provisions of ERISA may entitle the child to continuation coverage under the plan. The employer must continue to withhold employee contributions and may not disenroll (or eliminate coverage for) the child(ren) unless:

1. The employer is provided satisfactory written evidence that:
   a. The court or administrative child support order referred to in this Notice is no longer in effect; or
   b. The child(ren) is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment from the plan; or

2. The employer eliminates family health coverage for all of its employees.

## POSSIBLE SANCTIONS

An employer may be subject to sanctions or penalties imposed under State law and/or ERISA for discharging an employee from employment, refusing to employ, or taking disciplinary action against any employee because of medical child support withholding, or for failing to withhold income, or transmit such withheld amounts to the applicable plan(s) as the Notice directs. Sanctions or penalties may be imposed under State law against an employer for failure to respond and/or for non-compliance with this Notice.

## NOTICE OF TERMINATION OF EMPLOYMENT

In any case in which the above employee's employment terminates, the employer must promptly notify the Issuing Agency listed above of such termination. This requirement may be satisfied by sending to the Issuing Agency a copy of Part A with response 4 checked or any notice the employer is required to provide under the continuation coverage provisions of ERISA or the Health Insurance Portability and Accountability Act.

## EMPLOYEE LIABILITY FOR CONTRIBUTION TO PLAN

The employee is liable for any employee contributions that are required under the plan(s) for enrollment of the child(ren) and is subject to appropriate enforcement. The employee may contest the withholding under this Notice based on a mistake of fact (such as the identity of the obligor). Should an employee contest the withholding under this Notice, the employer must proceed to comply with the employer responsibilities in this Notice until notified by the Issuing Agency to discontinue withholding. To contest the withholding under this Notice, the employee should contact the Issuing Agency at the address and telephone number listed on the Notice. With respect to plans subject to ERISA, it is the view of the Department of Labor that Federal Courts have jurisdiction if the employee challenges a determination that the Notice constitutes a Qualified Medical Child Support Order.

## CONTACT FOR QUESTIONS

If you have any questions regarding this Notice, you may contact the Issuing Agency at the address and telephone number listed on page 1 of this Notice.

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## NATIONAL MEDICAL SUPPORT NOTICE - PART B
## MEDICAL SUPPORT NOTICE TO PLAN ADMINISTRATOR

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 (CSPIA). Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law. The rights of the parties and the duties of the plan administrator under this Notice are in addition to the existing rights and duties established under such 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: SACRAMENTO DCSS<br>Issuing Agency Address:<br>PO BOX 269112<br>SACRAMENTO CA 95826-9112<br><br>Notice Date: 08/15/2017<br>CSE Agency Case Identifier: 200000001870868<br>Telephone Number: (866) 901-3212<br>FAX Number: (916) 875-7499 | Court or Administrative Authority:<br>SUPERIOR COURT OF CALIFORNIA, COUNTY OF SACRAMENTO<br>Order Date: 07/28/2017<br>Order Identifier: FL-9874<br>Document Tracking Identifier:<br>Employer web site:<br>See NMSN Instructions: http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form |

123456788
Employer/Withholder's Federal EIN Number

RE: RABBIT, ROGER
Employee's Name (Last, First, MI)

ABC
Employer/Withholder's Name

316-31-3113
Employee's Social Security Number

1000 MAIN STREET
SACRAMENTO, CA 95859
Employer/Withholder's Address

185 MAIN AVE
SACRAMENTO, CA 95838
Employee's Mailing Address

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

SACRAMENTO COUNTY DEPARTMENT OF CHILD SUPPORT SERVICES
Substituted Official/Agency Name

Custodial Parent's Mailing Address

PO BOX 269112
SACRAMENTO CA 95826-9112
Substituted Official/Agency Address
(Required if Custodial Parent's mailing address is left blank)

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

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

Mailing Address of a Representative of the Child(ren)

| Child(ren)'s Name(s) | Gender | DOB | SSN | Child(ren)'s Name(s) | Gender | DOB | SSN |
|---|---|---|---|---|---|---|---|
| PETER RABBIT | M | 02/02/2010 | | | | | |
| | | | | | | | |
| | | | | | | | |

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 20 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: 1210-0113 Expiration Date: 08/31/2019.**

## PLAN ADMINISTRATOR RESPONSE

(To be completed and returned to the Issuing Agency within 40 business days after the date of the Notice, or sooner if reasonable)

Case # _____ (to be completed by the issuing agency)

This Notice was received by the plan administrator on _____.

1. This Notice was determined to be a "qualified medical child support order, " on _____. Complete **Response 2 or 3, and 4,** if applicable.

2. The participant (employee) and alternate recipient(s) (child(ren)) are to be enrolled in the following family coverage.

a. The child(ren) is/are currently enrolled in the plan as a dependent of the participant.

b. There is only one type of coverage provided under the plan. The child(ren) is/are included as dependents of the participant under the plan.

c. The participant is enrolled in an option that is providing dependent coverage and the child(ren) will be enrolled in the same option.

d. The participant is enrolled in an option that permits dependent coverage that has not been elected; dependent coverage will be provided.

Coverage is effective as of __/__/____ (includes waiting period of less than 90 days from date of receipt of this Notice). The child(ren) has/have been enrolled in the following option (if plan is insured, identify provider, policy and group numbers): _____. Any necessary withholding should commence if the employer determines that it is permitted under State and Federal withholding and/or prioritization limitations.

3. There is more than one option available under the plan and the participant is not enrolled. The Issuing Agency must select from the available options. Each child is to be included as a dependent under one of the available options that provide family coverage. If the Issuing Agency does not reply within 20 business days of the date this Response is returned, the child(ren), and the participant if necessary, will be enrolled in the plan's default option, if any: _____

4. 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.

5. This Notice does not constitute a "qualified medical child support order" because:

The name of the child(ren) or participant is unavailable.

The mailing address of the child(ren) (or a substituted official) or participant is unavailable.

The following child(ren) is/are at or above the age at which dependents are no longer eligible for coverage under the plan _____ (insert name(s) of child(ren)).

Plan Administrator or Representative:

Name: _____ Telephone Number: _____

Title: _____ Date: _____

Address: _____

ABC ROGER RABBIT 300000005018210

# INSTRUCTIONS TO PLAN ADMINISTRATOR

This Notice has been forwarded from the employer identified above to you as the plan administrator of a group health plan maintained by the employer (or a group health plan to which the employer contributes) and in which the noncustodial parent/participant identified above is enrolled or is eligible for enrollment.

This Notice serves to inform you that the noncustodial parent/participant is obligated by an order issued by the court or agency identified above to provide health care coverage for the child(ren) under the group health plan(s) as described on **Part B.**

(A) If the participant and child(ren) and their mailing addresses (or that of a Substituted Official or Agency) are identified above, and if coverage for the child(ren) is or will become available,this Notice constitutes a "qualified medical child support order" (QMCSO) under ERISA or CSPIA, as applicable. (If any mailing address is not present, but it is reasonably accessible, this Notice will not fail to be a QMCSO on that basis.) You must, within 40 business days of the date of this Notice, or sooner if reasonable:

(1) Complete Part B - Plan Administrator Response - and send it to the Issuing Agency:

(a) if you checked Response 2:

(i) notify the noncustodial parent/participant named above, each named child, and the custodial parent that coverage of the child(ren) is or will become available (notification of the custodial parent will be deemed notification of the child(ren) if they reside at the same address);

(ii) furnish the custodial parent a description of the coverage available and the effective date of the coverage, including, if not already provided, a summary plan description and any forms, documents, or information necessary to effectuate such coverage, as well as information necessary to submit claims for benefits;

(b) if you checked Response 3:

(i) if you have not already done so, provide to the Issuing Agency copies of applicable summary plan descriptions or other documents that describe available coverage including the additional participant contribution necessary to obtain coverage for the child(ren) under each option and whether there is a limited service area for any option;

(ii) if the plan has a default option, you are to enroll the child(ren) in the default option if you have not received an election from the Issuing Agency within 20 business days of the date you returned the Response. If the plan does not have a default option, you are to enroll the child(ren) in the option selected by the Issuing Agency.

(c) if 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 whose duration is determined by a measure other than the passage of time (for example, the completion of a certain number of hours worked), complete Response 4 on the Plan Administrator Response and return to the employer and the Issuing Agency, and notify the participant and the custodial parent; and upon satisfaction of the period or requirement, complete enrollment under Response 2 or 3, and

(d) upon completion of the enrollment, transfer the applicable information on Part B - Plan Administrator Response to the employer for a determination that the necessary employee contributions are available. Inform the employer that the enrollment is pursuant to a National Medical Support Notice.

(B) If within 40 business days of the date of this Notice, or sooner if reasonable, you determine that this Notice does not constitute a QMCSO, you must complete Response 5 of Part B - Plan Administrator Response and send it to the Issuing Agency, and inform the noncustodial parent/participant, custodial parent, and child(ren) of the specific reasons for your determination.

(C) Any required notification of the custodial parent, child(ren) and/or participant may be satisfied by sending the party a copy of the Plan Administrator Response, if appropriate. You may choose to furnish these notifications electronically in accordance with the requirements of the Department of Labor's electronic disclosure regulation codified at 29 C.F.R. 2520.104b-1(c).

## UNLAWFUL REFUSAL TO ENROLL.

Enrollment of a child may not be denied on the ground that: (1) the child was born out of wedlock; (2) the child is not claimed as a dependent on the participant's Federal income tax return; (3) the child does not reside with the participant or in the plan's service area; or (4) because the child is receiving benefits or is eligible to receive benefits under the State Medicaid plan. If the plan requires that the participant be enrolled in order for the child(ren) to be enrolled, and the participant is not currently enrolled, you must enroll both the participant and the child(ren) regardless of whether the participant has applied for enrollment in the plan. All enrollments are to be made without regard to open season restrictions.

## PAYMENT OF CLAIMS

A child covered by a QMCSO, or the child's custodial parent, legal guardian, or the provider of services to the child, or a State agency to the extent assigned the child's rights, may file claims and the plan shall make payment for covered benefits or reimbursement directly to such party.

## PERIOD OF COVERAGE

The alternate recipient(s) shall be treated as dependents under the terms of the plan. Coverage of an alternate recipient as a dependent will end when similarly situated dependents are no longer eligible for coverage under the terms of the plan. However, the continuation coverage provisions of ERISA or other applicable law may entitle the alternate recipient to continue coverage under the plan. Once a child is enrolled in the plan as directed above, the alternate recipient may not be disenrolled unless:

(1) The plan administrator is provided satisfactory written evidence that either:

(a) the court or administrative child support order referred to above is no longer in effect, or

(b) the alternate recipient is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment from the plan;

(2) The employer eliminates family health coverage for all of its employees; or

(3) Any available continuation coverage is not elected, or the period of such coverage expires.

## CONTACT FOR QUESTIONS

If you have any questions regarding this Notice, you may contact the Issuing Agency at the address and telephone number listed above.

## Paperwork Reduction Act Notice

The Issuing Agency asks for the information on this form to carry out the law as specified in the Employee Retirement Income Security Act or the Child Support Performance and Incentive Act, as applicable. You are required to give the Issuing Agency the information. You are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Issuing Agency needs the information to determine whether health care coverage is provided in accordance with the underlying child support order. The average time needed to complete and file the form is estimated below. These times will vary depending on the individual circumstances.

| | Learning about the law or the form | ..... | Preparing the form |
|---|---|---|---|
| First Notice | 1 hr. ___ | ..... | 1 hr., 45 min. |
| Subsequent Notices | ----- | ..... | 20 min. |

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# STATEMENT OF OBLIGOR'S RIGHTS AND PROCEDURES REGARDING A NATIONAL MEDICAL SUPPORT NOTICE (NMSN) OR HEALTH INSURANCE ASSIGNMENT ORDER

DCSS 0361 (09/02/05)

The following Family Code (FC) sections inform you how and when to notify the county court that has your child support order if you want to exercise your right to contest or end a NMSN or other health insurance assignment order.

Under FC section 3765, you have the right to contest a NMSN or other health insurance assignment order if:

- No order to maintain health insurance has been issued;
- The amount to be withheld for premiums is more than the law allows, or is more than the court ordered amount;
- The cost of the increased health insurance premium is unreasonable;
- You are not the person who is ordered to provide health insurance;
- The child(ren) is, or will otherwise be, provided with health insurance coverage; or
- The employer's choice of coverage is not appropriate.

Under FC section 3770, you have the right to ask the court to end a NMSN or other health insurance assignment order if:

- A new order has been entered that is inconsistent with the existing NMSN or health insurance assignment order;
- Your employer has discontinued health insurance coverage once available to you;
- You believe that there is good cause to terminate the NMSN or health insurance assignment order; or
- The child(ren) for which you are ordered to provide health insurance have died or emancipated.

Under FC section 3762, "good cause" is limited to any one of the conditions listed above or a finding by the court that enforcement of the NMSN or health insurance assignment order would cause extraordinary hardship to you.

If any of the above applies to you, you must file the necessary paperwork with the county court if you want to contest or end the order. The court will provide you with a date to appear. You will be required to attend the hearing and show proof of the reason enforcement should stop. Based on the information provided to the court, the court may end the NMSN or other health insurance assignment order and/or make any other order it finds appropriate. The reasons you provide to the court may also create a change in circumstance which could result in a modification of your child support order.

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