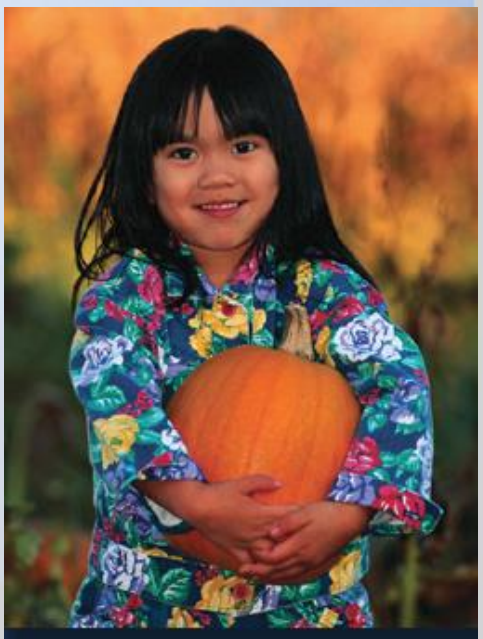
2016 EMPLOYER WORKSHOP

"Building towards a brighter future for children and families"

Your cooperation directly benefits CHILDREN!



WELCOME

Kim Cagno

Director, San Mateo County DCSS

&

Phyllis Nance

Director, Alameda County DCSS

EXPERT PANEL

Patty Arteaga

Program Manager, San Mateo County DCSS

Ryan Micka

DCSS Employer Services, California DCSS

Vangeria Harvey

Attorney, Alameda County DCSS

Michelle Henry

Outreach Manager, California SDU

OVERVIEW

Michelle Arrington
Alameda County DCSS

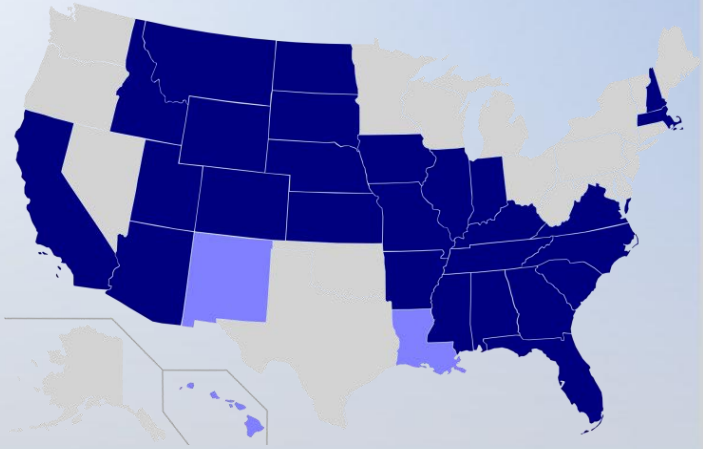
PURPOSE

- Build lasting partnerships in the collection of support for families
- Educate and engage employers about our services and their responsibilities
- Provide employers with tools to make processing deductions easier

CHILD SUPPORT PROGRAM

1.3 Million Children In CA

16 Million Children In USA



STRUCTURE OF THE PROGRAM

OCSE
- Federal Office of Child Support Enforcement

DCSS
- California Department of Child Support Services

LCSA
- 58 Counties with 51 Local Child Support Agencies

SERVICES PROVIDED BY THE LOCAL CHILD SUPPORT AGENCY (LCSA)

- Locate services
- Establish paternity
- Establish/Enforce/Modify child and medical support orders
- Collect and Distribute child support

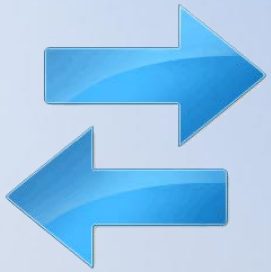
WHY YOU MATTER

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

EMPLOYERS MAKE A DIFFERENCE

$2.6 Billion in child support collected

90% disbursed to families



70% collected through withholding

COMMONLY USED CHILD SUPPORT TERMS

- **CP** – Custodial party or obligee; the person who receives payments
- **NCP** – Non-Custodial party or obligor; the person who pays child support
- **Arrears** – Any past due child support that includes interest
- **Local Child Support Agency (LCSA)** – The county department of child support services responsible for providing services directly to the public
- **State Disbursement Unit (SDU)** – The state entity responsible for receiving and sending all child support payments
- **IV-D Services –** When a party is receiving child support services through a local child support agency
- **NON-IV-D Services** – When parties do not have an LCSA case, but have their private employer income withholding payments processed by the SDU

REPORTING NEW HIRES & EMPLOYER VERIFICATIONS

Terez McCall

Alameda County DCSS

CONFIDENTIALITY

- Case records are confidential
- Employers can ONLY be given information to comply with the IWO or NMSN
- Refer your employee to us for case specific questions

WHY SO MUCH PAPER WORK… ?!?

Employers provide valuable assistance at every step of the process

Intake → Locate → Establish → Enforce → Financial → Closure

CHILD SUPPORT GUIDELINES

- Income
- Tax Filing
- Custody & visitation percentage
- Health insurance
- Child care
- Minor child(ren) from another relationship
- Other costs as related to employment

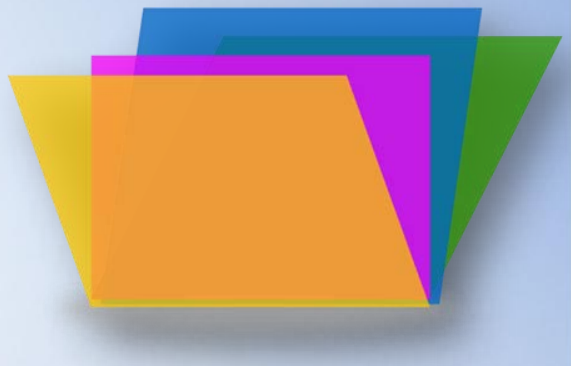
REPORTING NEW HIRES

Timeframes:

- Report New Hires within **20 days of their start date**
- Report Independent Contractors within **20 days of contracting** if all of the following apply:
  - Form 1099 for the services
  - You pay $600 or more
  - Individual or Sole Proprietorship

REPORTING NEW HIRES

Reports are matched against child support records to help:



- Locate parents
- Provide up to date earning records
- Establish/Enforce orders for support

REPORTING NEW HIRES

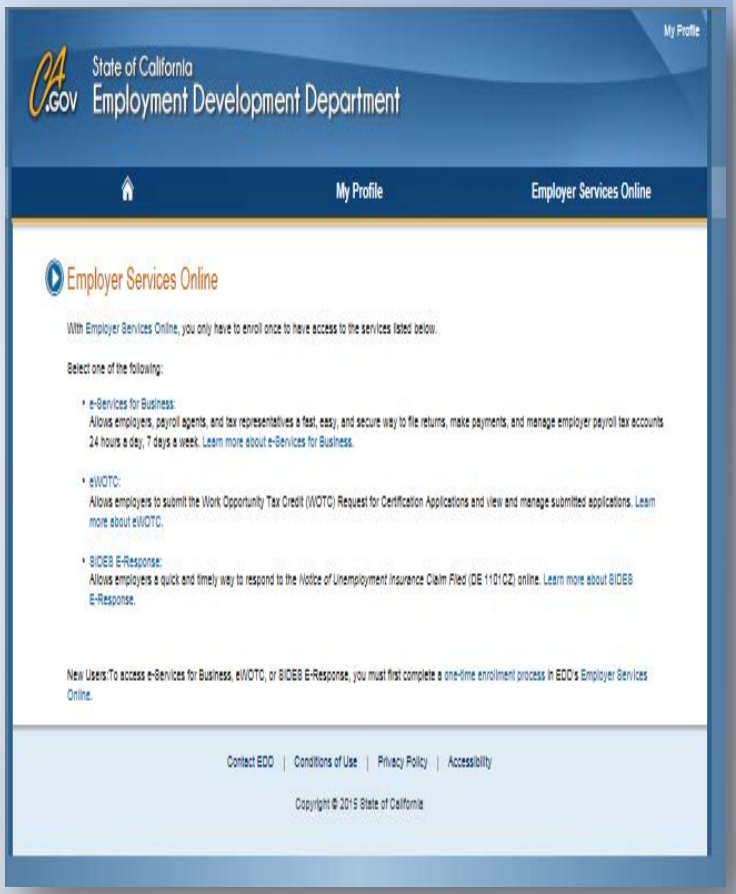
Form DE 34 “Report of New Employees” or

Form DE 542 “Report of Independent Contractors”

REPORTING NEW HIRES

- Mail –Document Management Group, MIC 96 PO Box 997016 West Sacramento, CA 95799
- Fax – (916) 319-4400
- Online – eServices for business

https://eddservices.edd.ca.gov



REPORTING NEW HIRES

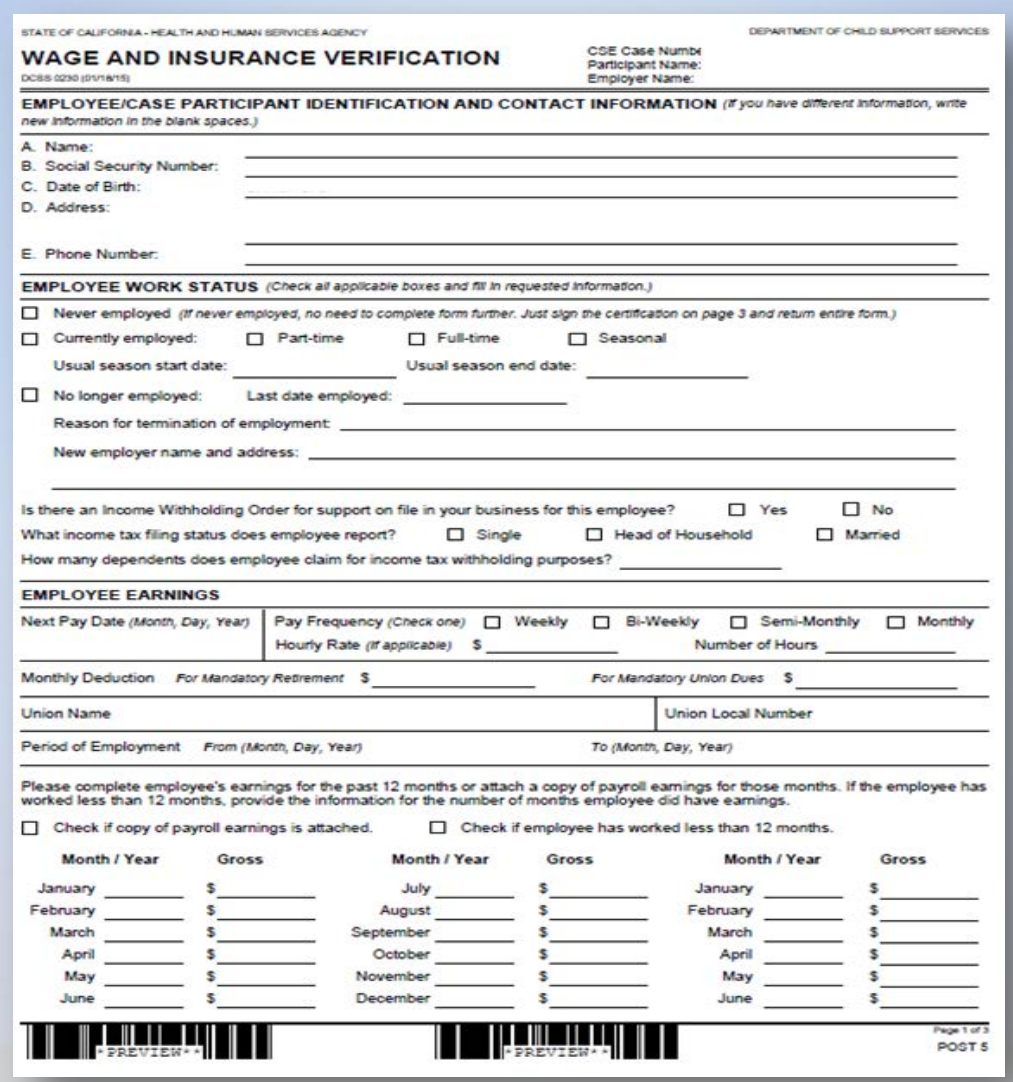
For additional information regarding New Hire Reporting:

- Visit your local EDD Employment Tax Office
- Phone: Tax Payer Assistance Center:
  (888) 745-3886, Monday – Friday 8 a.m. to 5 p.m.
- Online: www.edd.ca.gov

DOCUMENTS REQUESTING INFORMATION FROM EMPLOYERS

- Wage and Insurance Verification
- Letters from local child support agency (LCSA)

WAGE AND INSURANCE VERIFICATION FORM



STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF CHILD SUPPORT SERVICES

WAGE AND INSURANCE VERIFICATION

DCSS 0230 (01/16/15)

CSE Case Numbe
Participant Name:
Employer Name:

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

A. Name:
B. Social Security Number:
C. Date of Birth:
D. Address:

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	$

PREVIEW *PREVIEW*

Page 1 of 3

POST 5

WAGE VERIFICATIONS

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: _____

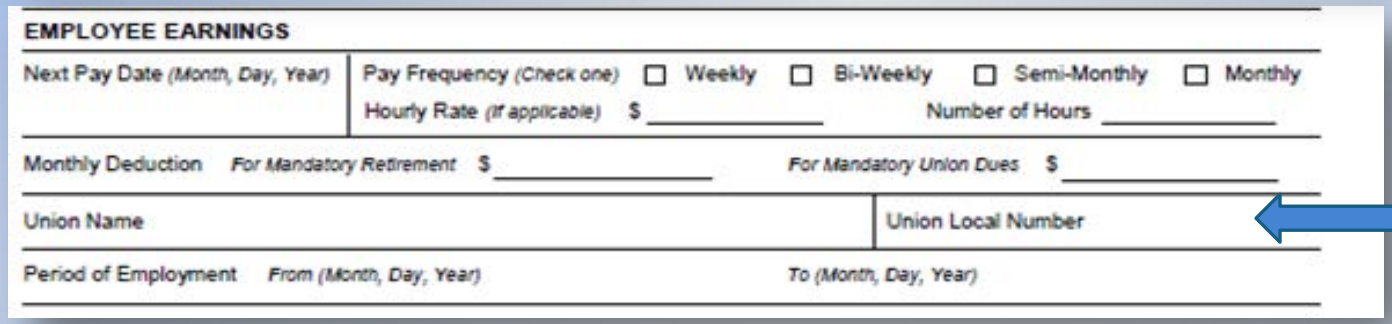
☐ No longer employed: Last date employed: _____

Reason for termination of employment: _____

New employer name and address: _____

_____

Employee work status, start date, termination date and reason



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)*

Pay date, hourly rate, mandatory retirement, union dues

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	$

Employee's earnings for the past 12 months

INSURANCE VERIFICATIONS

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: $_____

Health Insurance coverage costs for medical, dental and vision

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

Contact information for company payroll/HR representative

LCSA LETTER

ATTN: PERSONNEL DIRECTOR:

Regarding the above named employee, we have been informed by the Post Office that the address we have on file for this employee is no longer correct. Please provide his/her updated address below and return it to our office. Until such time, we have located this employee in care of your office. Thank you for your continued assistance.

EMPLOYEE'S OLD ADDRESS:

___Enter Street Address Here___
___Enter City, State, Zip Here___

New address: _____

Worksite address: _____

Employee's phone number: _____

Please contact us at (866) 901-3212 with the above case number if you have any questions.

Sincerely,

T. MCCALL
Child Support Representative

UPDATING YOUR INFORMATION

- Legal Business Name
- FEIN
- Business Address
- Business Phone/Fax
- Email address
- Health Insurance

UPDATING YOUR INFORMATION

- ABC Plumbing
- ABC Plumbing Inc.
- ABC Plumbing Company
- ABC Plumbing Co., Inc.

Consistent reporting can decrease paperwork from our office to yours!

UPDATING YOUR INFORMATION

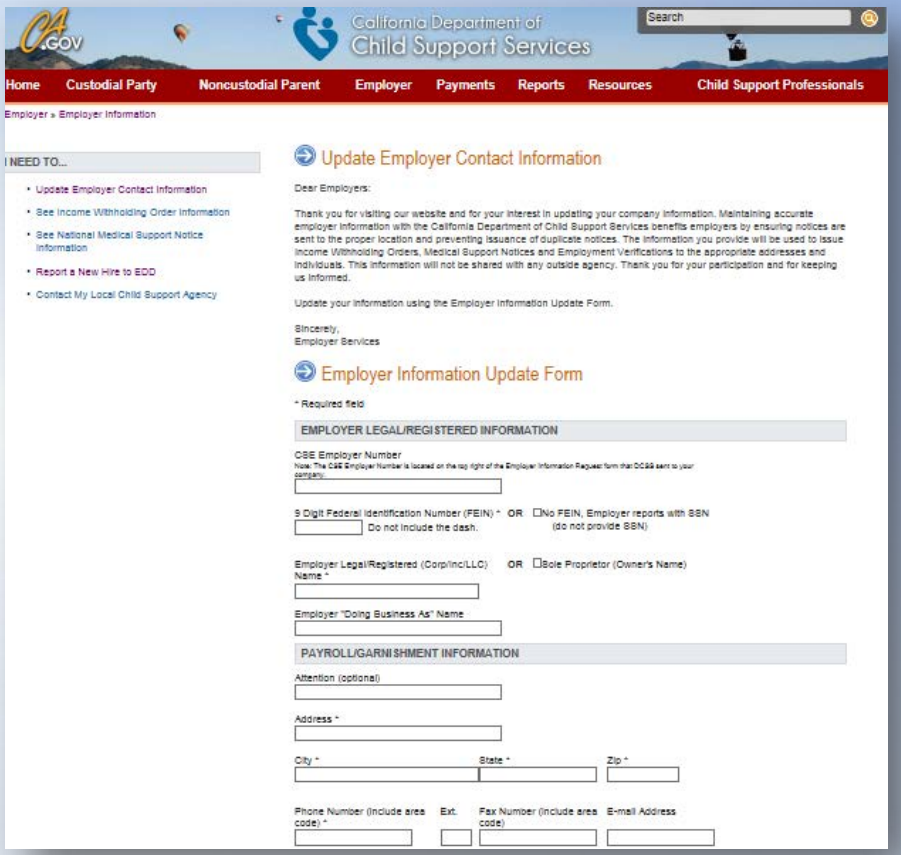
- By phone:

  Employer Services Team

  (888) 898-1743

- Online:

  Employer Information Update Form



www.childsup.ca.gov/employer/employerinformation.aspx

INCOME WITHHOLDING ORDERS (IWO)

Maria Sturdivant
Alameda County DCSS

INCOME WITHHOLDING ORDERS

IWOs are mandated, not discretionary

When an IWO is received, it is the employer's responsibility to withhold the specified amount and remit to the appropriate State Disbursement Unit until you receive an IWO Termination Notice

INCOME WITHHOLDING ORDERS

A couple of things to keep in mind…

- An IWO issued by a Court or an Administrative Agency from another State is just as binding on an employer as one from a CA Court

- Honor the existing IWO until you receive an Amended IWO or Termination IWO

INCOME WITHHOLDING ORDERS

A couple of things to keep in mind…

- Emancipation dates can vary depending on unique circumstances and/or by a different State's laws
- California Code of Civil Procedure directs employers to keep an IWO on file for one year after separation of employment

DELIVERY OF YOUR IWO

- USPS – Paper packet
- Fax
- Electronically – e-IWO

IMPACTS TO YOUR EMPLOYEE

CREDIT FOR PAYMENTS ARE GIVEN ON THE DAY IT IS RECEIVED AT THE SDU. **MISSED PAYMENTS CAN RESULT IN:**

- Negative Credit Reporting
- 10% per annum interest
- State License Suspension
- Bank Levies
- Passport Denial

PRIVATE vs. AGENCY IWOs

IV-D AGENCY-ISSUED IWOs

- Within **10 days** of receipt, notify and provide copy of the IWO and the *Request for Hearing Earnings Assignment* to your employee
- Within **10 days** begin withholding the first pay period after the *Remittance Date* found at the top of page 4
- Remit payments within **7 days** of withholding

REMITTANCE INFORMATION

Employer's Name: _____ Employer FEIN: _____

Employee/Obligor's Name: _____ SSN: _____

CSE Agency Case Identifier: 20000000 Order Identifier: _____

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 06/24/2016. 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)

TOP OF PAGE 4 OF THE IWO

REQUEST FOR HEARING REGARDING EARNING ASSIGNMENT

FL-450

ATTORNEY OR PARTY WITHOUT ATTORNEY *(Name, State Bar number, and address)*:

20000000

TELEPHONE NO.: FAX NO. *(Optional)*:

E-MAIL ADDRESS *(Optional)*:

ATTORNEY FOR *(Name)*:

FOR COURT USE ONLY

SUPERIOR COURT OF CALIFORNIA, COUNTY OF

STREET ADDRESS:

MAILING ADDRESS:

CITY AND ZIP CODE:

BRANCH NAME:

Page 11 of the IWO

PETITIONER/PLAINTIFF:

RESPONDENT/DEFENDANT:

OTHER PARENT:

REQUEST FOR HEARING REGARDING EARNINGS ASSIGNMENT

CASE NUMBER:

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.

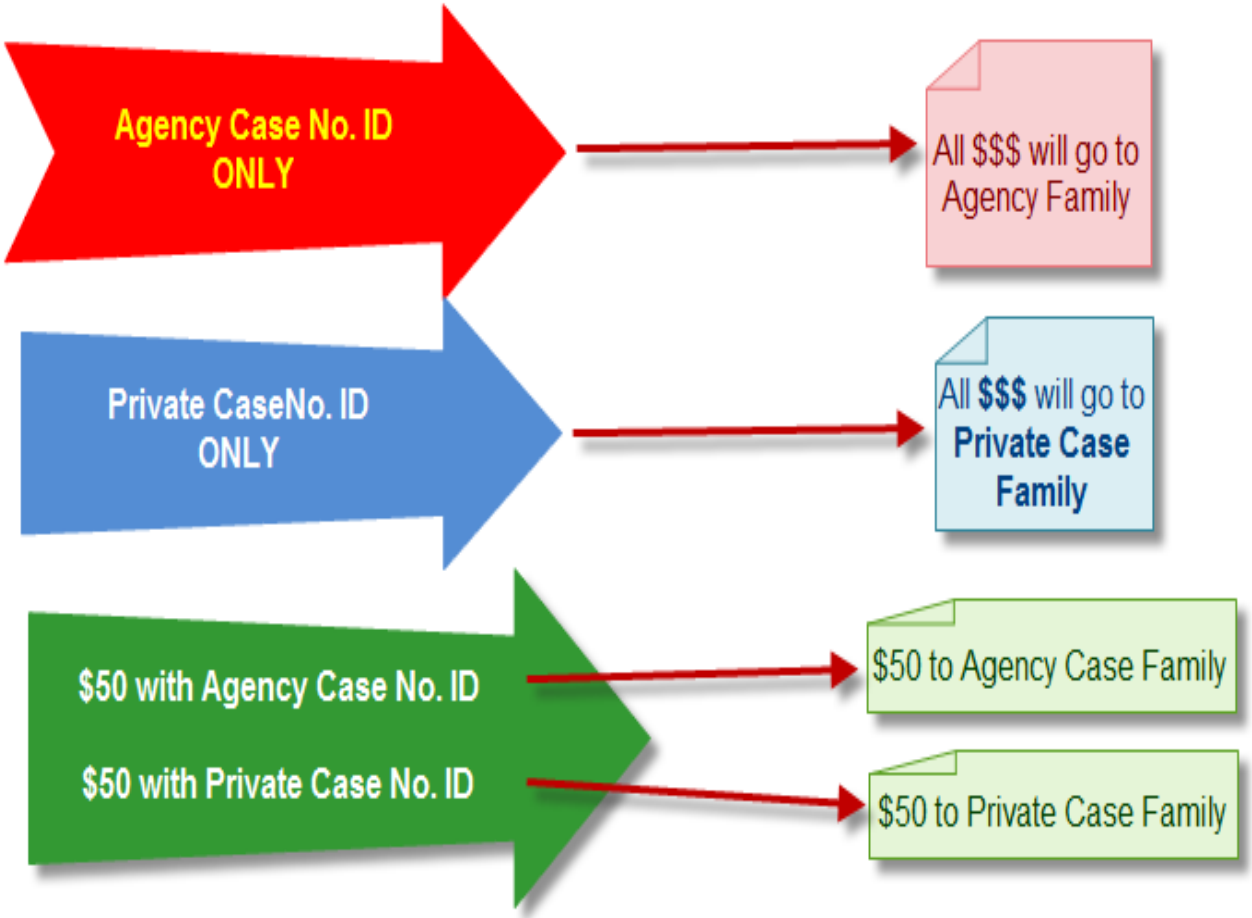
PRIVATE vs. AGENCY IWOs

PRIVATELY ISSUED IWOs

(NON IV-D)

- Upon receipt make a copy and retain the original. Send copy to SDU (FL-195 Case Registry Form)
- SDU will create a case number and provide that to you. ***Payment must not be sent until that case number is obtained***
- Remit payments to the SDU within **7 days** of withholding

PRIVATE vs. AGENCY IWOs



WHAT ARE "EARNINGS"?

Defined by **Family Code Section 5206** as:

- Wages/Salary
- Bonuses/Commissions
- Vacation Pay
- Retirement
- Dividends, Royalties, Residuals
- Payment for independent contractor services

HOW MUCH IS "TOO MUCH" ?

Generally, the maximum deduction that can be withheld to satisfy **involuntary deductions** is 50% of an employee's **net disposable income**

- If all IWOs are CA IV-D child support obligations, and total exceeds 50% of net, withhold 50% and send to the CA SDU
- SDU will divide funds based on Federal hierarchy

NET DISPOSABLE INCOME (NDI)

Calculate NDI using gross earnings less ONLY:

- Mandatory deductions

  State & Federal Tax, SDI

- Mandatory union dues
- Mandatory retirement (NOT 401k)
- Tax Lien* (only if it's in place prior to receiving the child support garnishment)

CALCULATING MAXIMUM DEDUCTION

Example –

Gross Income = $1000.00 minus:

- Federal Income Tax - 150.00
- State Income Tax - 58.00
- FICA 1 - 100.00
- FICA 2 - 20.00
- SDI - 10.00

Net Disposable Income = $662.00

Maximum Deduction = $662.00 x .50 = 331.00

PRIORITY OF DEDUCTIONS OUTSIDE OF IWOS

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

PRIORITY OF DEDUCTIONS WITHIN IWOs

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

DEDUCTING

- We are not asking that you change your payroll cycle to adjust to the child support deductions
- Child Support Orders are not first come, first served
- If you receive multiple orders for the **same children and custodial party**, contact all state agencies and senders involved

COMPETING ORDERS EXAMPLE

MULTIPLE ORDERS FROM DIFFERENT STATES

Order	Amount (Current Support)	Amount/Total	Amount Paid On Order (NDI is $360 Maximum Deduction is $180)
A	$90	39.65% ($90/$227)	$71.37 ($180 x 39.65%)
B	$75	33.04% ($75/$227)	$59.47 ($180 x 33.04%)
C	$62	27.31% ($62/$227)	$49.16 ($180 x 27.31%)
Total	$227	100%	$180

MULTIPLES ORDERS FROM DIFFERENT STATES

If any money remains, follow the same steps for the next type of support in order or priority.

BONUS & LUMP SUM PAYMENTS

These payments made to employees include:

- Bonuses
- Severance or buy-out payments
- Cash Awards
- Vacation payouts
- Incentive payments
- Retirement incentives
- Commissions

BONUS & LUMP SUM PAYMENTS

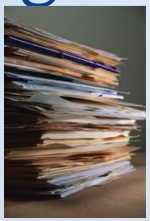
Report bonus or lump sum payments **prior** to payout by contacting CA DCSS
lumpsumresponseteam@dcss.ca.gov or (916) 464-6640

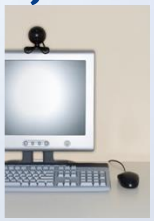
One Team Does It All!

PAPERLESS OPTION!

e-IWO (Electronic IWO)

- Receive Income Withholding Order electronically
- Notify child support agencies of terminations and lump sums
- Acknowledge acceptance or rejection of IWOs





e-IWO Questions?

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

Contact: Bill Stuart

Email: william.stuart@acf.hhs.gov

PAPERLESS OPTION!

e-IWO (Electronic IWO)

System-to-System Interface

- Receive more than 100-200 per year
- Requires significant IT resources for programming
- 2-3 months implementation

No Programing Option

- Receive less than 100-200 per year
- PDF copy of IWO is provided

PAPERLESS OPTION!

e-IWO (Electronic IWO)

Benefits

- Child support gets to the family sooner
- Automated responses
- Ensures uniform IWO data from all states
- Increases accuracy and reliability of data

IWOs

SEPARATION OF EMPLOYMENT

or

CHANGE IN WORK STATUS

Return one of the following notices or report changes by phone at:

(866) 901-3212

eTerm is now available for electronic reporting of terminated employees.
Contact the Federal Employer Services Team at: employerservices@acf.hhs.gov

IWOs

Employer's Name: _____ Employer FEIN: _____

Employee/Obligor's Name: _____ SSN: _____

CSE Agency Case Identifier: 20000000 Order Identifier: _____

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:

Page 6 of the IWO

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: _____

_____

EMPLOYEE STATUS REPORT

CSE Case Number:
Noncustodial Parent:

DCSS Form 0522
Online at
childsup.ca.gov

Court Case Number:
Employer Name:

Employer Address:
ATTN: PAYROLL

EMPLOYEE STATUS REPORT

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 following address 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. ☐ On _____ (Date), the above employee:
   ☐ was terminated ☐ voluntarily left our employment
   ☐ is presently on lay-off status and will return to work on _____ (Estimated return date).
5. ☐ The employee named above is currently employed at _____ (Company name, if known)
   _____ (Address, if known).

TERMINATION OF BENEFITS/EMPLOYMENT NOTICE

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF CHILD SUPPORT SERVICES

TERMINATION OF BENEFITS / EMPLOYMENT NOTICE

DCSS 0114 (08/19/05)

TO:

FROM:

DCSS Form 0114 Online at childsup.ca.gov

PHONE: (866) 901-3212

EMPLOYEE: AUSTIN A HORN, II

SSN:

DOB:

Participant Number:

TERMINATION OF BENEFITS / EMPLOYMENT NOTICE

***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	
COBRA HEALTH INSURANCE AVAILABLE? ☐ NO ☐ YES, coverage thru: _____ DATE		
DATE OF TERMINATION - EMPLOYMENT	REASON FOR TERMINATION	SUBJECT TO REHIRE? ☐ NO ☐ YES
LAST KNOWN HOME ADDRESS (Street address, City, State, Zip code)		TELEPHONE NUMBER
NEW EMPLOYER'S NAME (if known)		TELEPHONE NUMBER
NEW EMPLOYER'S ADDRESS (if known - Street address, City, State, Zip code)		

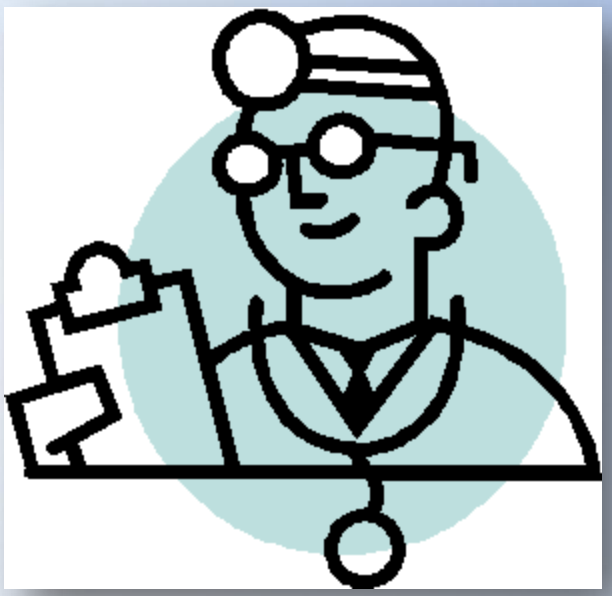
QUESTIONS?

NATIONAL MEDICAL SUPPORT NOTICES (NMSN)

Cari Watson
Alameda County DCSS

TYPES OF MEDICAL SUPPORT

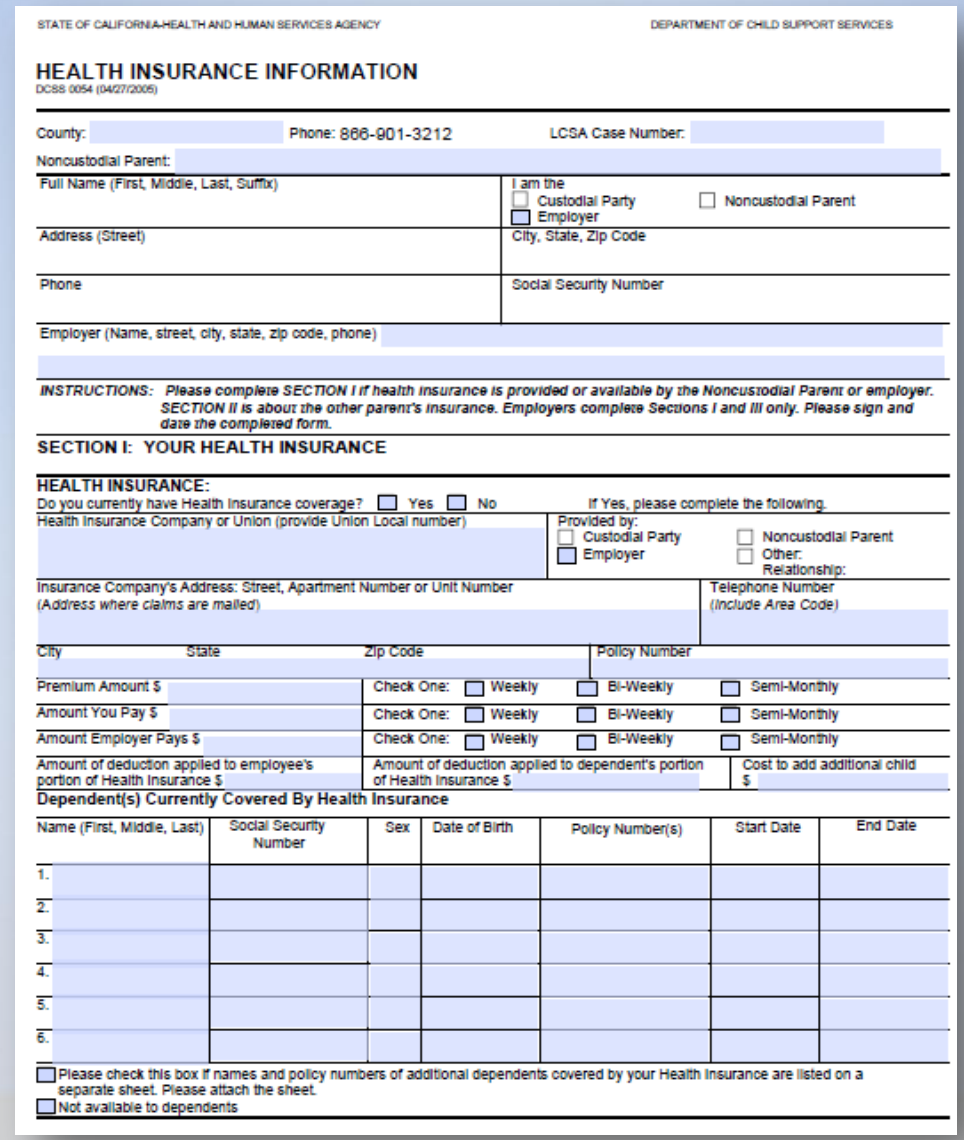
- Medical
- Dental
- Vision Care
- Prescriptions
- Mental Health



NMSN

- Health insurance must be provided to the employee's children even if the employee declines personal health coverage
- Not subject to open enrollment guidelines
- Once the child(ren) are enrolled, complete the Health Insurance Information Form which can be found at: www.childsup.ca.gov/IWOForms

HEALTH INSURANCE INFORMATION FORM



STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY — DEPARTMENT OF CHILD SUPPORT SERVICES

HEALTH INSURANCE INFORMATION

DCSS 0054 (04/27/2005)

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

Noncustodial Parent:

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

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

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

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 $

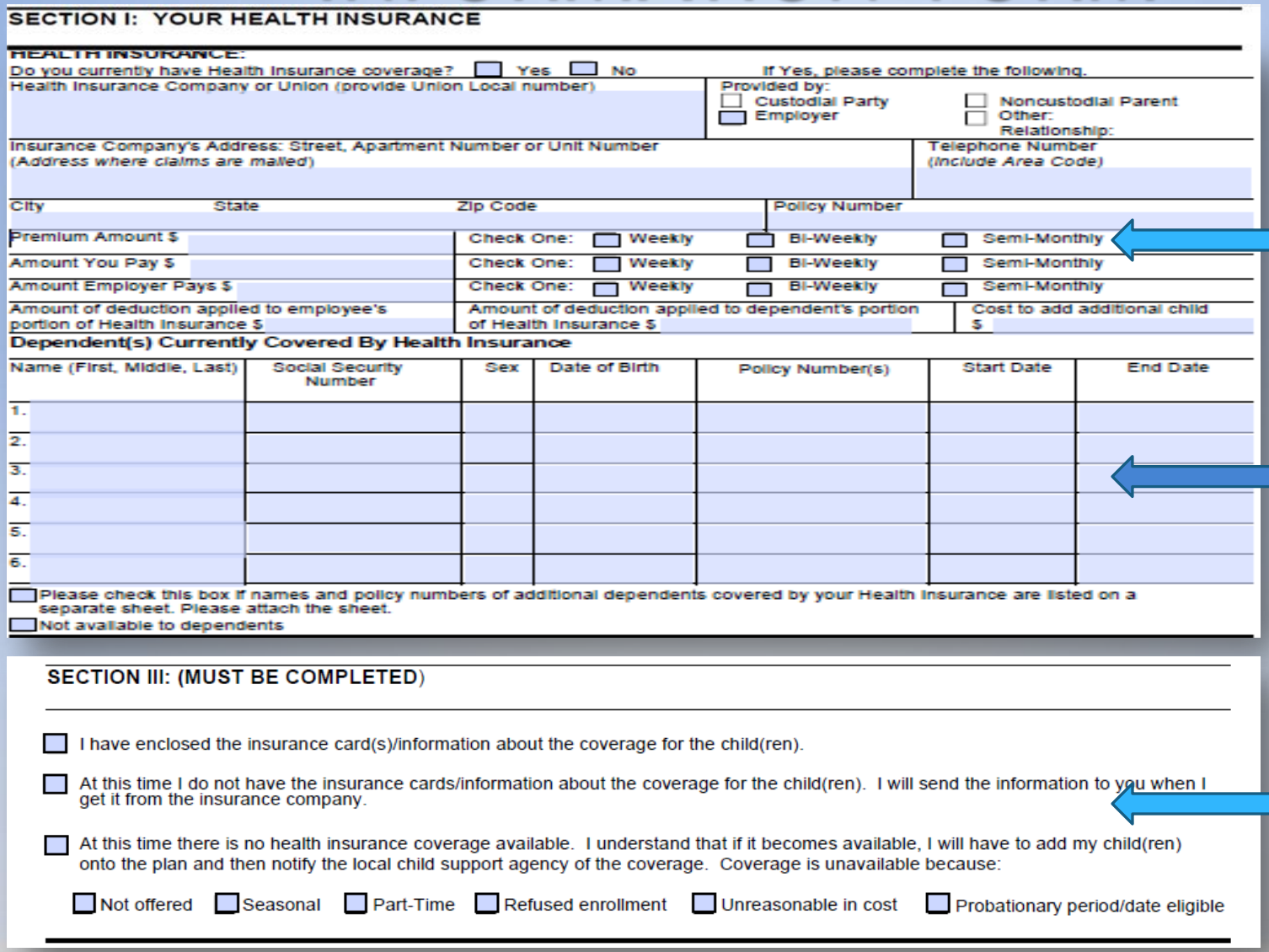
Dependent(s) Currently Covered By Health Insurance

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

HEALTH INSURANCE INFORMATION 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

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

Health Insurance coverage details and costs for medical, dental and vision

Coverage details for medical, dental and vision

Reasons health insurance coverage is not available

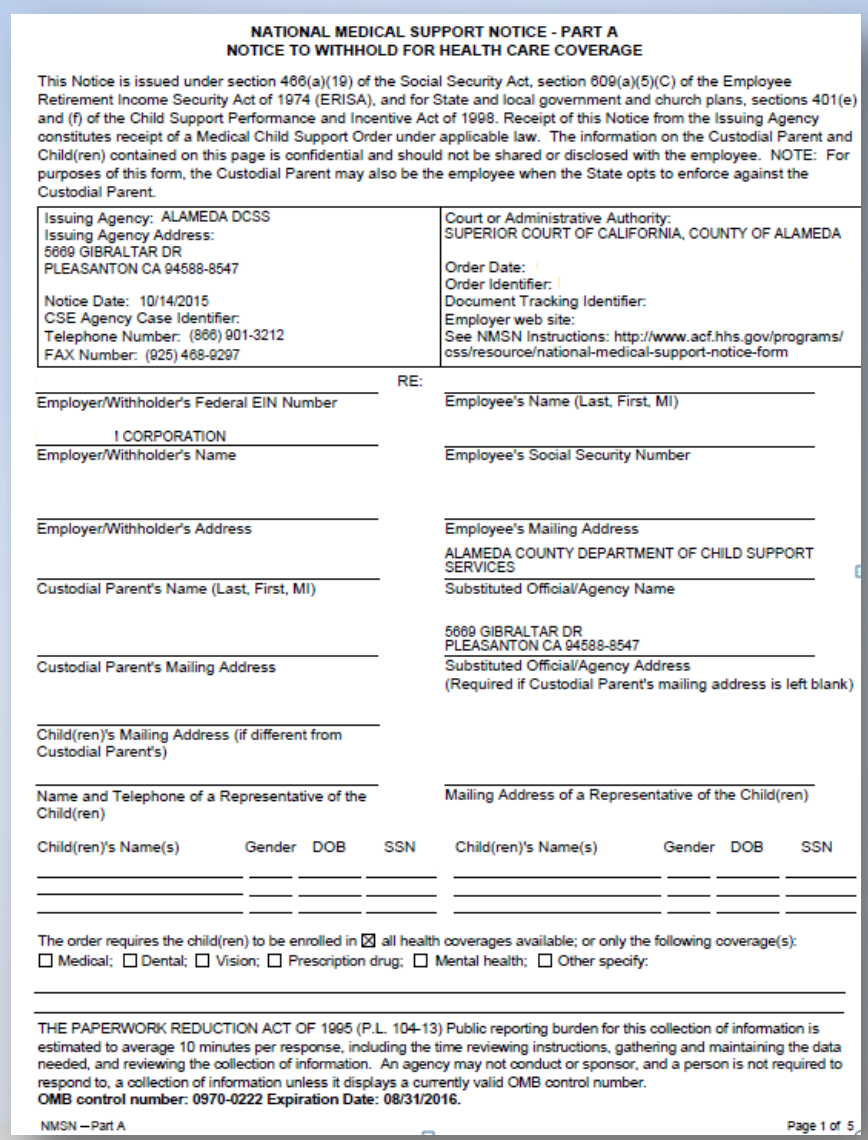
EMPLOYER RESPONSIBILITIES

- Within **10 business days** of receiving an NMSN, the employee must be notified that it was received
- If employee is no longer employed or health care is not available, **complete items 1-5 on the employer response form** & return to LCSA
- Within **20 business days,** employer must forward a copy of Part B Medical Support Notice to the health care plan administrator

EMPLOYER RESPONSIBILITIES

- If employee is subject to a waiting period, notify LCSA and the plan administrator
- Within **40 business days,** provide LCSA with a description of the coverage available
- Withhold any employee contributions required*
- Continue coverage until notified by the LCSA

NMSN FORM – PART A



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: ALAMEDA DCSS Issuing Agency Address: 5669 GIBRALTAR DR PLEASANTON CA 94588-8547 Notice Date: 10/14/2015 CSE Agency Case Identifier: Telephone Number: (866) 901-3212 FAX Number: (925) 468-9297	Court or Administrative Authority: SUPERIOR COURT OF CALIFORNIA, COUNTY OF ALAMEDA Order Date: Order Identifier: Document Tracking Identifier: Employer web site: See NMSN Instructions: http://www.acf.hhs.gov/programs/oss/resource/national-medical-support-notice-form

RE:

Employer/Withholder's Federal EIN Number

Employee's Name (Last, First, MI)

! CORPORATION
Employer/Withholder's Name

Employee's Social Security Number

Employer/Withholder's Address

Employee's Mailing Address

ALAMEDA COUNTY DEPARTMENT OF CHILD SUPPORT SERVICES
Custodial Parent's Name (Last, First, MI)

Substituted Official/Agency Name

5669 GIBRALTAR DR
PLEASANTON CA 94588-8547
Custodial Parent's Mailing Address

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

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: 08/31/2016.

NMSN FORM – PART B

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: ALAMEDA DCSS Issuing Agency Address: 5669 GIBRALTAR DR PLEASANTON CA 94588-8547 Notice Date: CSE Agency Case Telephone Number: (866) 901-3212 FAX Number: (925) 468-9297	Court or Administrative Authority: SUPERIOR COURT OF CALIFORNIA, COUNTY OF ALAMEDA Order Date: Order Identifier: Document Tracking Identifier: Employer web site: See NMSN Instructions: http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form

RE:

Employer/Withholder's Federal EIN Number

Employee's Name (Last, First, MI)

CORPORATION
Employer/Withholder's Name

Employee's Social Security Number

Employer/Withholder's Address

Employee's Mailing Address

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

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

Custodial Parent's Mailing Address

5669 GIBRALTAR DR
PLEASANTON CA 94588-8547
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

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: 03/31/2016.

NMSN FORM – PART B

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: _____

CALIFORNIA SENATE BILL 580

Employee must maintain health insurance, if available, for the child at reasonable or no cost

- "Reasonable" cost is not more than 5% of employee's gross income to add the child
- 50% of NCP's net disposable income (total current support + coverage)
- "Accessibility of Health Insurance" which means coverage is "within 50 miles of the supported child's residence"
- If the employee states the children are enrolled in alternative coverage

*Notify LCSA if it appears any of these situations apply

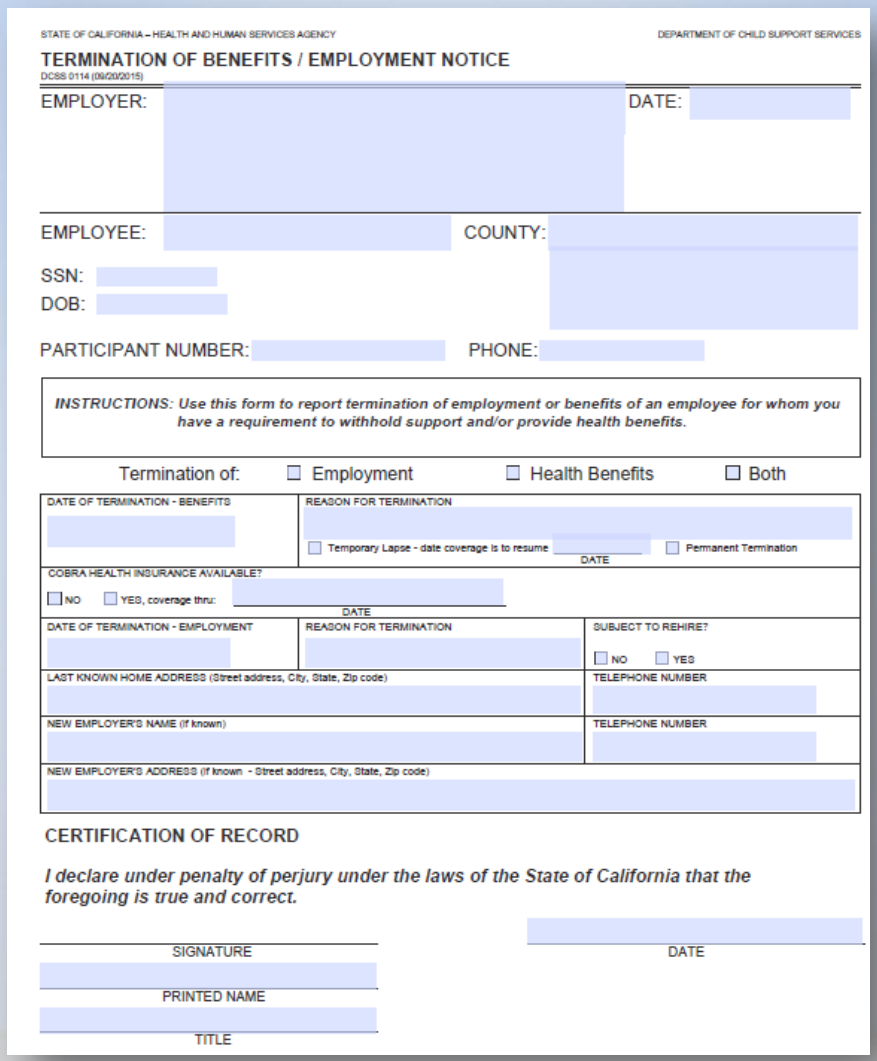
REPORTING EMPLOYEE SEPARATIONS

Notifying Your Local Child Support Agency (LCSA) When an Employee Separates Employment

- Report terminated employees promptly by completing and returning the Termination of Benefits/Employment and Health Insurance Information which can be found at www.childsup.ca.gov/IWOForms
- Return notice to the issuing Local Child Support Agency or contact them by phone to report at (866) 901-3212

eTerm is now available for electronic reporting of terminated employees.
Contact the Federal Employer Services Team at: employerservices@acf.hhs.gov

REPORTING EMPLOYEE SEPARATIONS



STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF CHILD SUPPORT SERVICES

TERMINATION OF BENEFITS / EMPLOYMENT NOTICE

DCSS 0114 (09/20/2015)

EMPLOYER:

DATE:

EMPLOYEE:

COUNTY:

SSN:

DOB:

PARTICIPANT NUMBER:

PHONE:

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

Termination of: ☐ Employment ☐ Health Benefits ☐ Both

DATE OF TERMINATION - BENEFITS	REASON FOR TERMINATION ☐ Temporary Lapse - date coverage is to resume _____ (DATE) ☐ Permanent Termination
COBRA HEALTH INSURANCE AVAILABLE? ☐ NO ☐ YES, coverage thru: _____ (DATE)	

DATE OF TERMINATION - EMPLOYMENT	REASON FOR TERMINATION	SUBJECT TO REHIRE? ☐ NO ☐ YES
LAST KNOWN HOME ADDRESS (Street address, City, State, Zip code)		TELEPHONE NUMBER
NEW EMPLOYER'S NAME (if known)		TELEPHONE NUMBER
NEW EMPLOYER'S ADDRESS (if known - Street address, City, State, Zip code)		

CERTIFICATION OF RECORD

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

SIGNATURE

DATE

PRINTED NAME

TITLE

MAKING PAYMENTS

Cari Watson

Alameda County DCSS

PAYMENT REMITTANCE

EMPLOYER RESPONSIBILITIES

- Deduct the appropriate amount from the withholding notice
- Remit payments within 7 days of deduction
- Provide identifying information about your employee(s)
- Forward payments to the appropriate state SDU

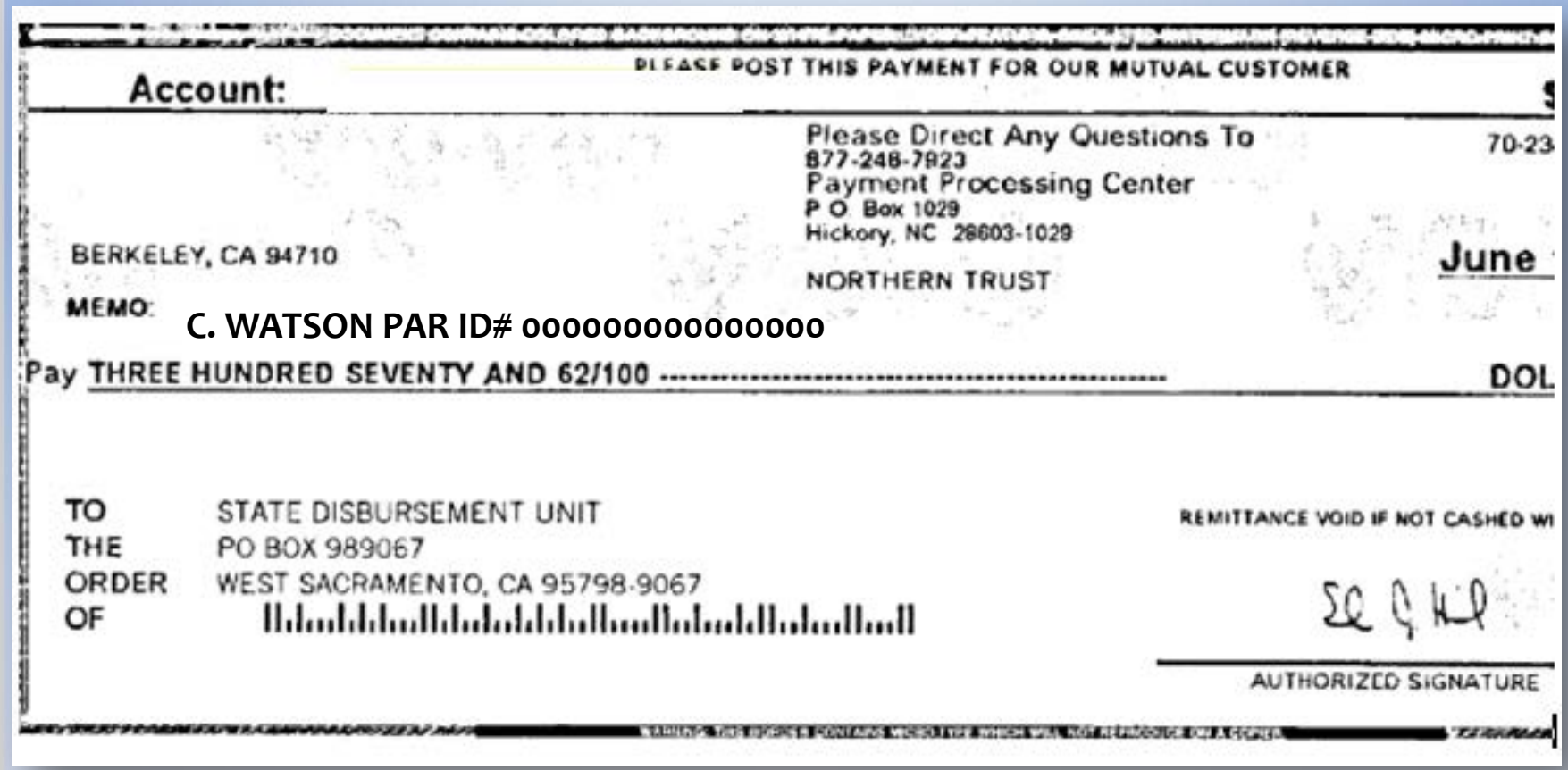
PAYMENT REMITTANCE

Include necessary identification information for each employee:

- **Employee name**
- **Social security number**
- **CSE participant number**
- **Child support case number provided by the SDU or other State**
- Date of withholding
- Amount of Payment

PAYMENT REMITTANCE

INSUFFICIENT INFORMATION



PLEASE POST THIS PAYMENT FOR OUR MUTUAL CUSTOMER

Account:

Please Direct Any Questions To
877-248-7923
Payment Processing Center
P O Box 1029
Hickory, NC 28603-1029

70-23

BERKELEY, CA 94710

NORTHERN TRUST

June

MEMO:

C. WATSON PAR ID# oooooooooooooo

Pay THREE HUNDRED SEVENTY AND 62/100 ----------

DOL

TO THE ORDER OF
STATE DISBURSEMENT UNIT
PO BOX 989067
WEST SACRAMENTO, CA 95798-9067

REMITTANCE VOID IF NOT CASHED WI

AUTHORIZED SIGNATURE

PAYMENT REMITTANCE

MULTIPLE EMPLOYEES, SAME SDU

CHECK REQUEST

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

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

EMP NAME	SSN #	SDU CASE #	PARTICIPANT ID#	AMOUNT
EMPLOYEE 1	XXX-XX-XXXX	000000000000000	XXXXXXXXXXXXXXX	279.00
EMPLOYEE 2	XXX-XX-XXXX	000000000000000	XXXXXXXXXXXXXXX	42.77
EMPLOYEE 3	XXX-XX-XXXX	000000000000000	XXXXXXXXXXXXXXX	11.53
EMPLOYEE 4	XXX-XX-XXXX	000000000000000	XXXXXXXXXXXXXXX	1,804.00
EMPLOYEE 5	XXX-XX-XXXX	000000000000000	XXXXXXXXXXXXXXX	368.02

PAY PERIOD ENDING: PAYROLL DATED: TOTAL: 2505.32

DELIVER:

PAYMENT OPTIONS

All child support payments must be remitted to the **State Disbursement Unit (SDU)**

Mail check payments **only** to:

State Disbursement Unit
P.O. Box 989067
West Sacramento, CA 95798

Payments should never be mailed directly to the Local Child Support Agency issuing the IWO

ELECTRONIC PAYMENT

Employers transmit payments through Automated Clearing House (ACH) network:

- ACH Credit – *Push* a payment from your account to the SDU account
- ACH Debit – *Pull* a payment from your account to the SDU account

ACH CREDIT PROCESS OVERVIEW

Contact SDU to Receive Guide and Enrollment Form

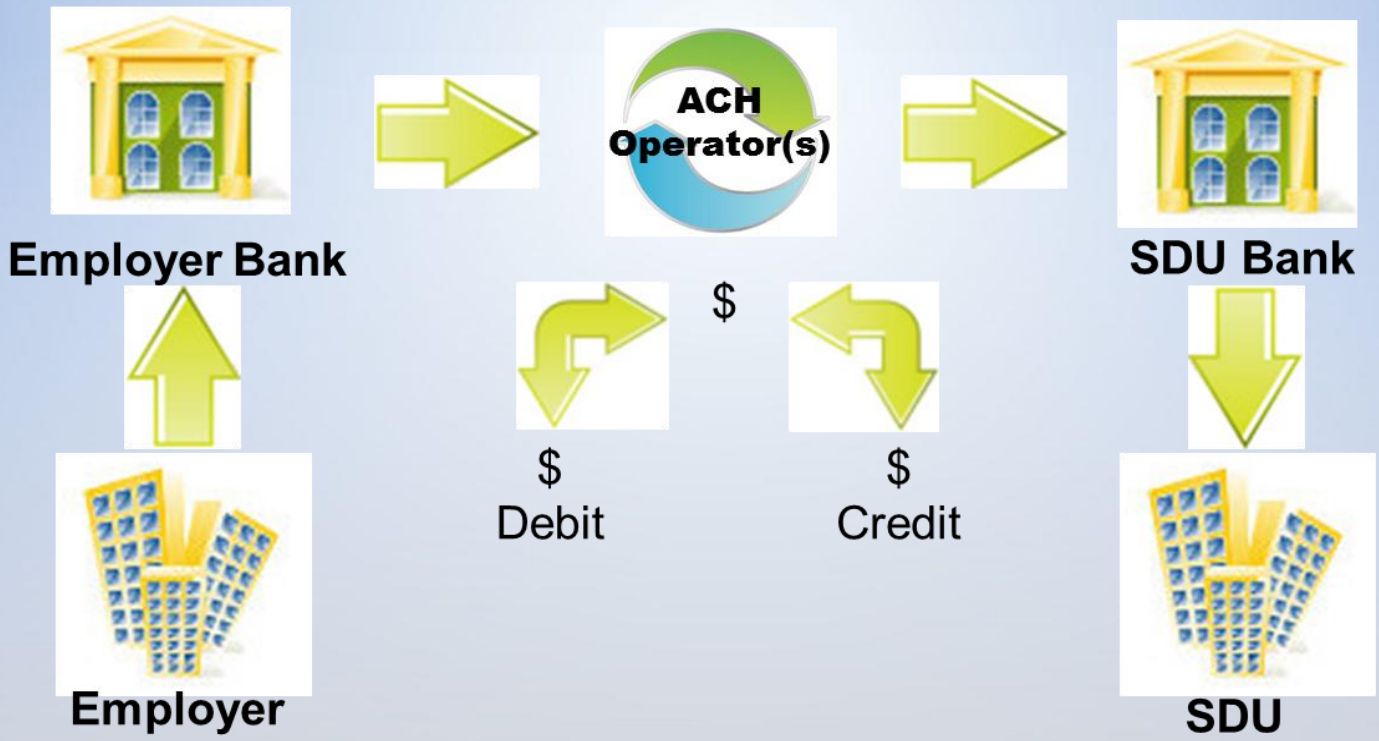
Receive Guide and Form

Complete and Return Form to SDU

Create and Send Test File to SDU

Receive Authorization from SDU to Remit

Make a Payment



ELECTRONIC PAYMENTS

- Online – Employers can complete the enrollment information at the SDU website: www.casdu.com
  (Employers can download or print the Employer Handbook)
- By phone – Employers can initiate the process by contacting the SDU at: (866) 901-3212
- By e-mail – Employers can send a request to the SDU at: casdu-electronichelpdesk@dcss.ca.gov
  (The SDU can send the employer an Enrollment Form)

ELECTRONIC PAYMENTS

- Fewer errors
- No lost checks
- Saves time and money
- Reduces risk of theft and fraud
- Faster SDU receipt and processing
- It's 'green'!

ROLES AND RESPONSIBLITIES

SDU, STATE AND COUNTY

California State Disbursement Unit (SDU)

- Collection Processing
- Electronic Help Desk

State (DCSS)

- Stop Payments
- Non-sufficient funds
- Non IV-D Customer Service
- Employer Verification Services

LCSA

- IV-D customer service & case management
- Questions regarding IWO, NMSN, etc.

One centralized phone number: (866) 901-3212

NSF RECOVERY UNIT

Employer must contact the NSF Recovery Unit **IMMEDIATELY** by phone: (888) 851-6317 (Monday - Friday 7:30 a.m. to 5 p.m. or email dcssnsfstoppay@dcss.ca.gov) IF:

- Employers determine they need to issue a stop payment on a recently remitted payment.
- To discuss the status of an unfunded collection or replacement of an unfunded collection
- If a payment was issued to the SDU by mistake

IMPORTANT: Employers should **NOT** place stop payments on remitted checks until the NSF Recovery Unit has been contacted

STAY CONNECTED

Michelle Arrington

Alameda County DCSS

STAY CONNECTED

Still Have Questions?

Case Specific Questions Call: (866) 901-3212

Visit the DCSS Employer Resource Center for more information:

www.childsup.ca.gov/employer.aspx

STAY CONNECTED

CALIFORNIA DEPARTMENT OF CHILD SUPPORT SERVICES

Customer Service
1-866-901-3212

EMPLOYER PHONE TREE FLOW CHART

Press 1 for the SDU

Stay on the line for the LCSA

SDU

State Disbursement Unit – Make A Payment

When you hear:
"To make a payment, press 1,"
Press 1 and you will be transferred to the SDU.

When you hear:
"If you are an employer making a child support payment, press 1,"

Press 1 again and you will hear:
"Please enter your company's nine-digit Federal Employer Identification Number."

LCSA

Local Child Support Agency – Ask about a Case

When you hear:
"Are you a parent or guardian calling about your case?"
Say, no, or to talk to an agent at any time say agent or press zero.
You will hear:
"Say employer, government agency, attorney or escrow title company."
Say, "Employer"
You will hear:
"What's the employee's Social Security Number?"
If you know the employee's SSN, press the numbers on your keypad.
If you don't know the SSN, say, "Let's go on" or press zero.
You will hear:
"Please tell me the county you would like to be transferred."
Say the name of the county you would like to be transferred or press the first four letters of the county's name using the touch-tone numbers on your phone.
If the case is not being managed by a county, say, "the state."

STAY CONNECTED

STAY CONNECTED

STAY CONNECTED

- State of California Department of Child Support Services (DCSS): www.childsup.ca.gov
- California Employment Development Department (EDD): www.edd.ca.gov
- Small Business Administration: www.sba.gov
- California State Disbursement Unit (SDU): www.casdu.com
- Department of Health and Human Services: www.chhs.ca.gov

BENEFITS

Michelle Arrington

Alameda County DCSS

BENEFITS

EMPLOYER

FAMILY

COMMUNITY

THANK YOU!

We couldn't have done it without your help!

QUESTIONS?

SURVEY

- For those attending via webinar, you will be sent an e-mail with a link to Survey Monkey
- For those attending in-person, please complete the survey provided in the handout and leave on your table for collection
- Thank you in advance, we value your feedback!