The Employer Workshop will start momentarily…

2022 Employer Workshop


KNOWLEDGE
IS POWER

Welcome

Liane Peck

Director, Solano County

Agenda

- Child Support Program Overview
- Reporting New Hires & Employer Verifications
- Income Withholding Orders/ e-IWO
- Remitting Payments
- Health Insurance & National Medical Support Notices
- Staying Connected
- Question & Answer Session
- Closing

Poll Time!

Are you a new attendee or a returning attendee to the employer workshop?

Goals

- **Educate** about our services and your responsibilities
- **Inform** with resources and tools to make processing requests easier
- **Engage** with questions and issues and produce solutions

Presenters

Caroline Castillo, Solano County

Salina Mansapit, Contra Costa County

Brandon Felix, Contra Costa County

Kanisha George, Santa Clara County

Overview

Caroline Castillo

Solano County

Child Support Program

Helps more than 1 in 5 children in the United States

Over 13.8 Million Children in the USA

Over 1.1 Million Cases in CA

Structure of the Program

OFFICE OF CHILD SUPPORT ENFORCEMENT

An Office of the Administration for Children & Families

CALIFORNIA
CHILD SUPPORT SERVICES

California State Disbursement Unit

1 IN 8

CHILDREN IN CALIFORNIA DEPEND ON A LOCAL CHILD SUPPORT AGENCY

Child Support
Directors Association

State, SDU, and LCSA

State Disbursement Unit (SDU)
- Collection processing
- Electronic help desk

Local Child Support Agency (LCSA)
- Agency customer service & case management
- Questions regarding IWO, NMSN, etc.

CA Child Support Services
- Stop payments
- Non-sufficient funds
- Non-agency customer service
- Employer verification services

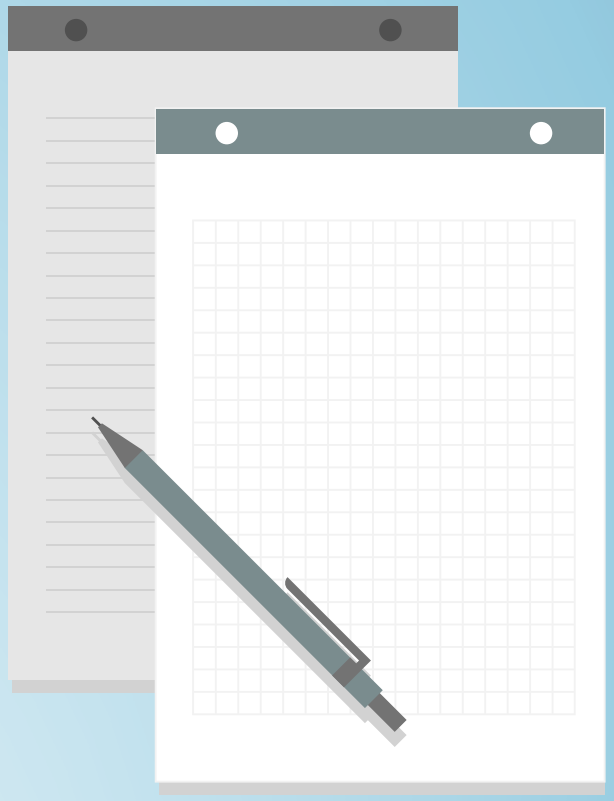
One Phone Number

866-901-3212

- Automated phone service
- Make a payment over the phone
- Connect with the Call Center or a caseworker at your LCSA
- Various language options are available

Confidentiality

- Case records are confidential
- Employers can only receive information needed to comply with:
  - Income Withholding Orders (IWOs) or
  - National Medical Support Notices (NMSNs)
- Refer your employee to 866-901-3212 for case specific questions



Reporting New Hires and Employer Verifications

Salina Mansapit

Contra Costa County

New Hire Reporting Guidelines

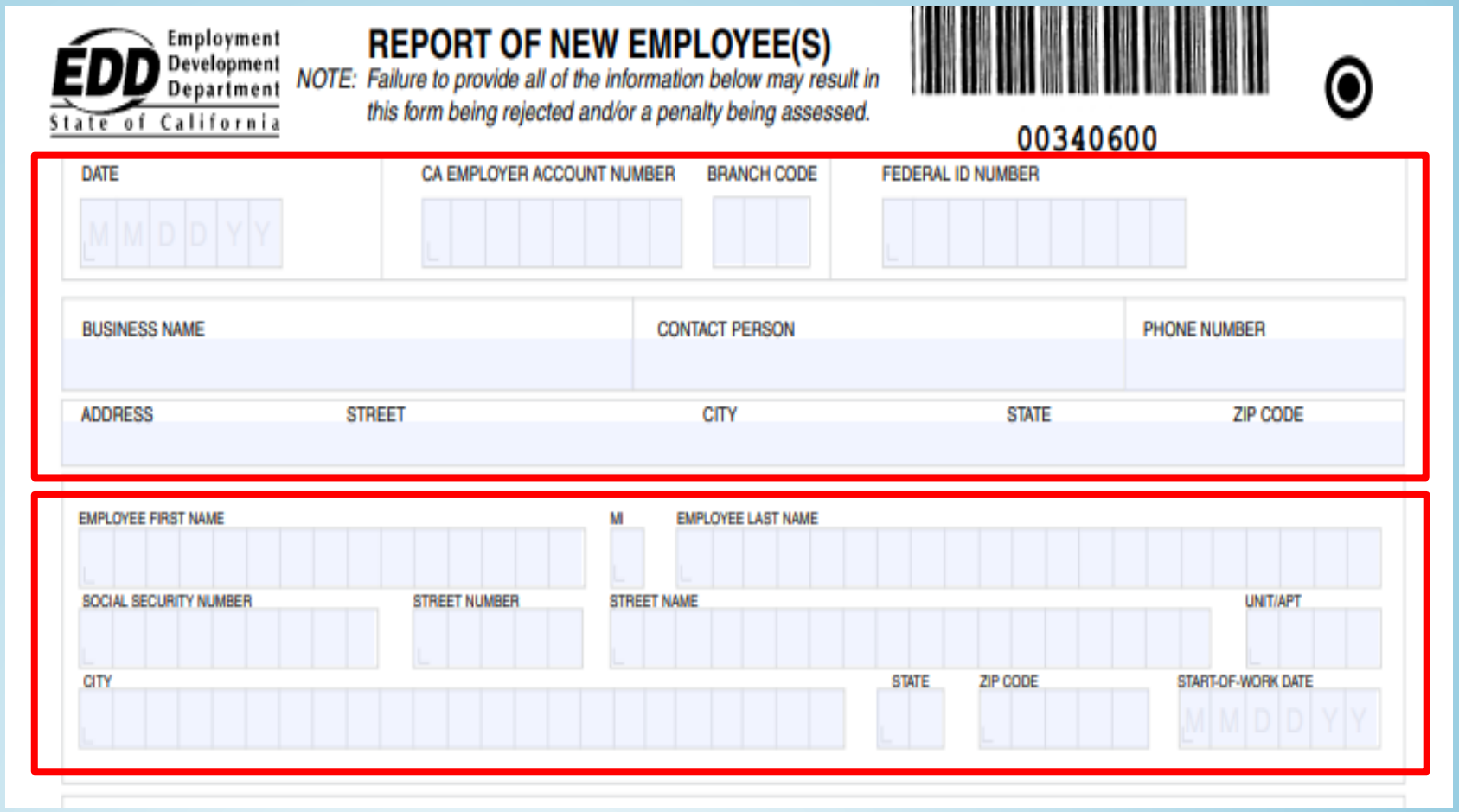
- Report New Hires and Rehires within **20 days of their start date**
- Report Independent Contractors within **20 days of contracting** if any of the following apply:
  - Form 1099 for the services
  - You pay $600 or more
  - You enter into a contract of $600 or more
  - Individual or Sole Proprietorship

New Hire Reporting Forms

EDD Form DE 34
for New or Rehired Employees

Employer Information →

Employee Information →



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 (MMDDYY) | 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

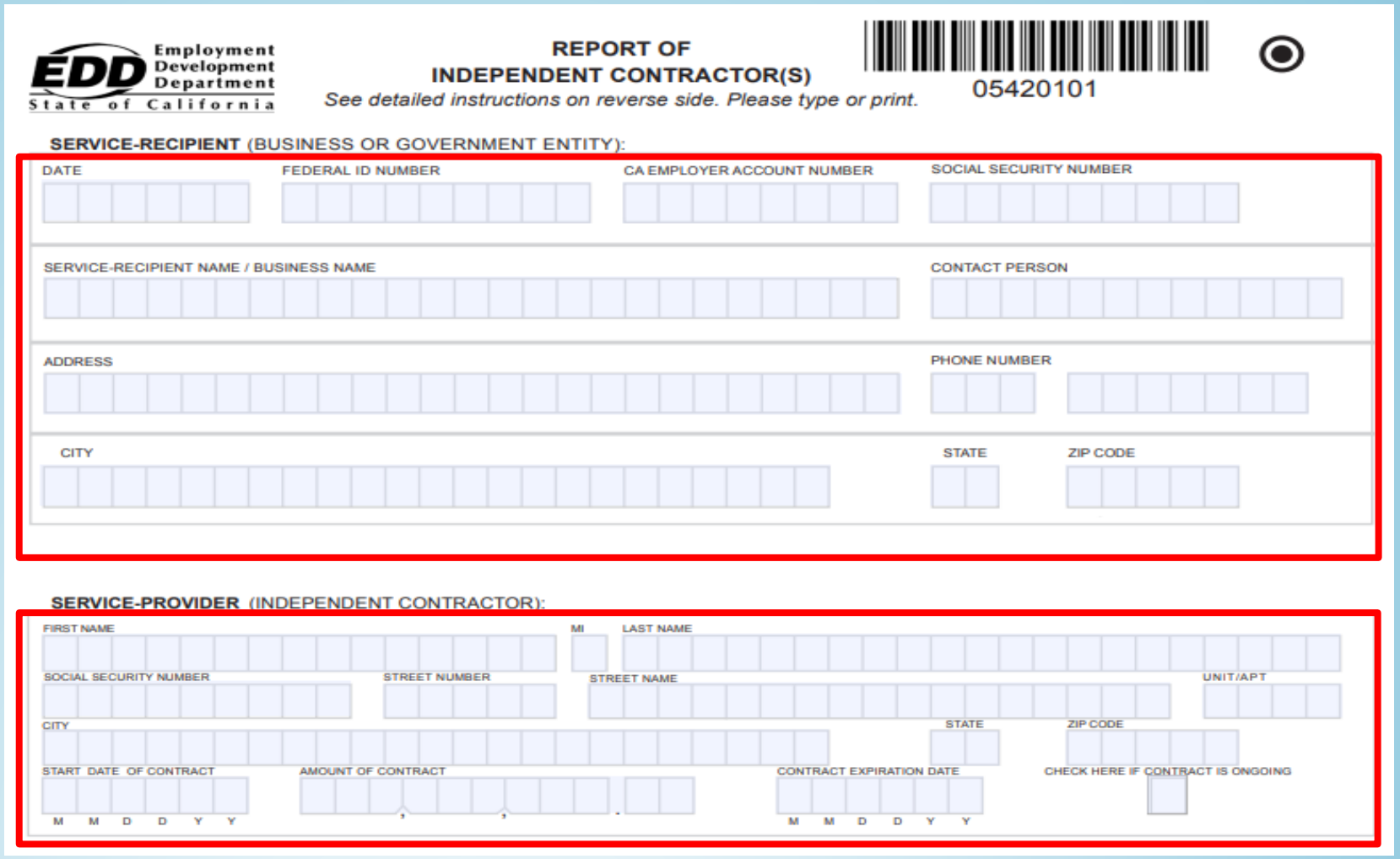
CITY | STATE | ZIP CODE | START-OF-WORK DATE (MMDDYY)

Independent Contractor Reporting Form

EDD Form DE 542
for Independent Contractors

Employer Information

Independent Contractor Information



Employment Development Department
State of California

REPORT OF INDEPENDENT CONTRACTOR(S)

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

05420101

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

New Hire Reporting Options

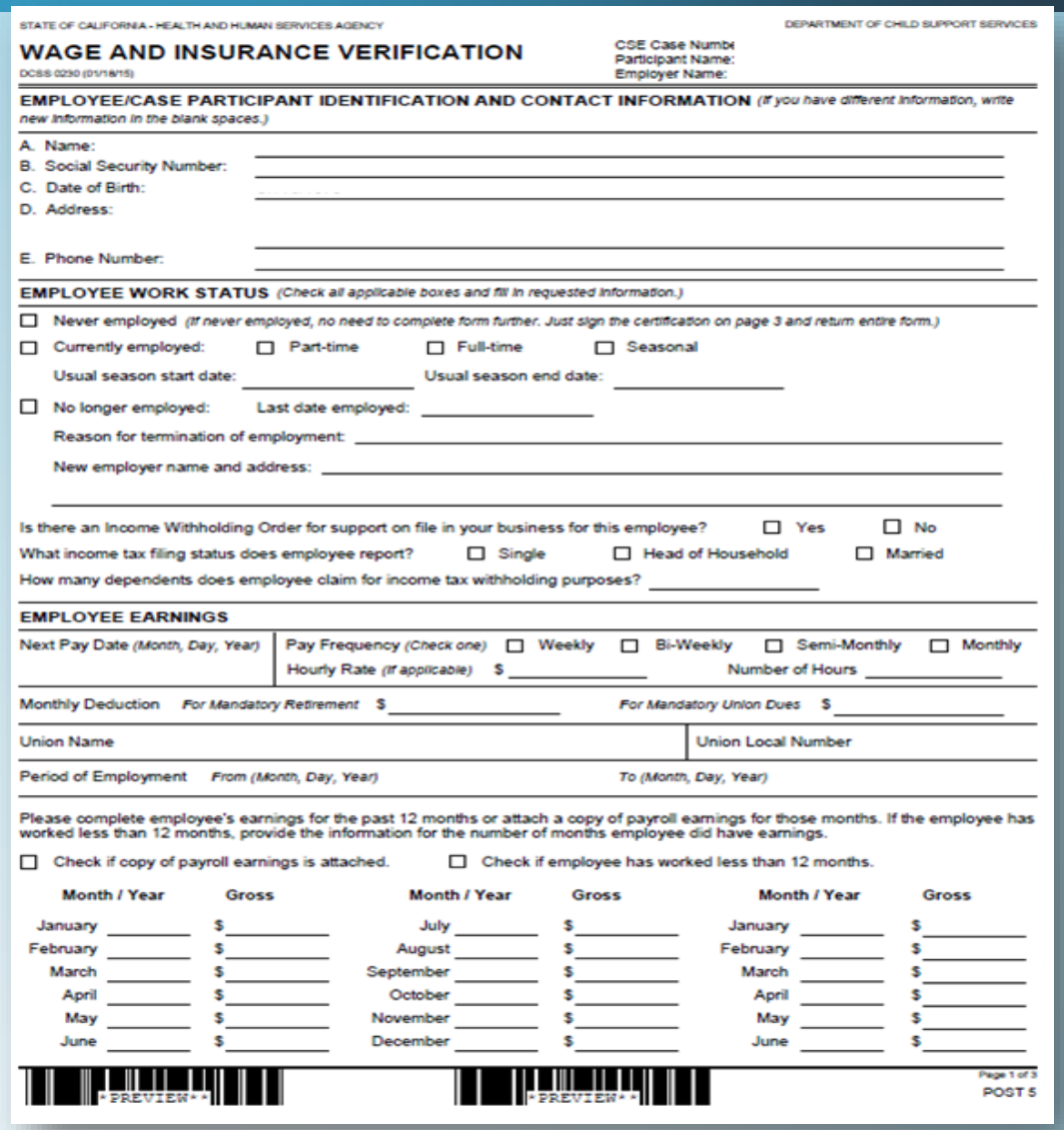
- **Online** e-Services for Business
  https://eddservices.edd.ca.gov
- **Mail** Document Management Group, MIC 96
  PO Box 997016
  West Sacramento, CA 95799
- **Fax** (916) 319-4400

For Additional Information:

- **Online** https://edd.ca.gov
- **In-Person** Visit a local EDD Employment Tax Office
- **Phone** Call The Taxpayer Assistance Center:
  (888) 745-3886 Monday – Friday 8 a.m. to 5 p.m.

Wage and Insurance Verification Form

A request to verify an employee's employment status, wages, and benefits



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

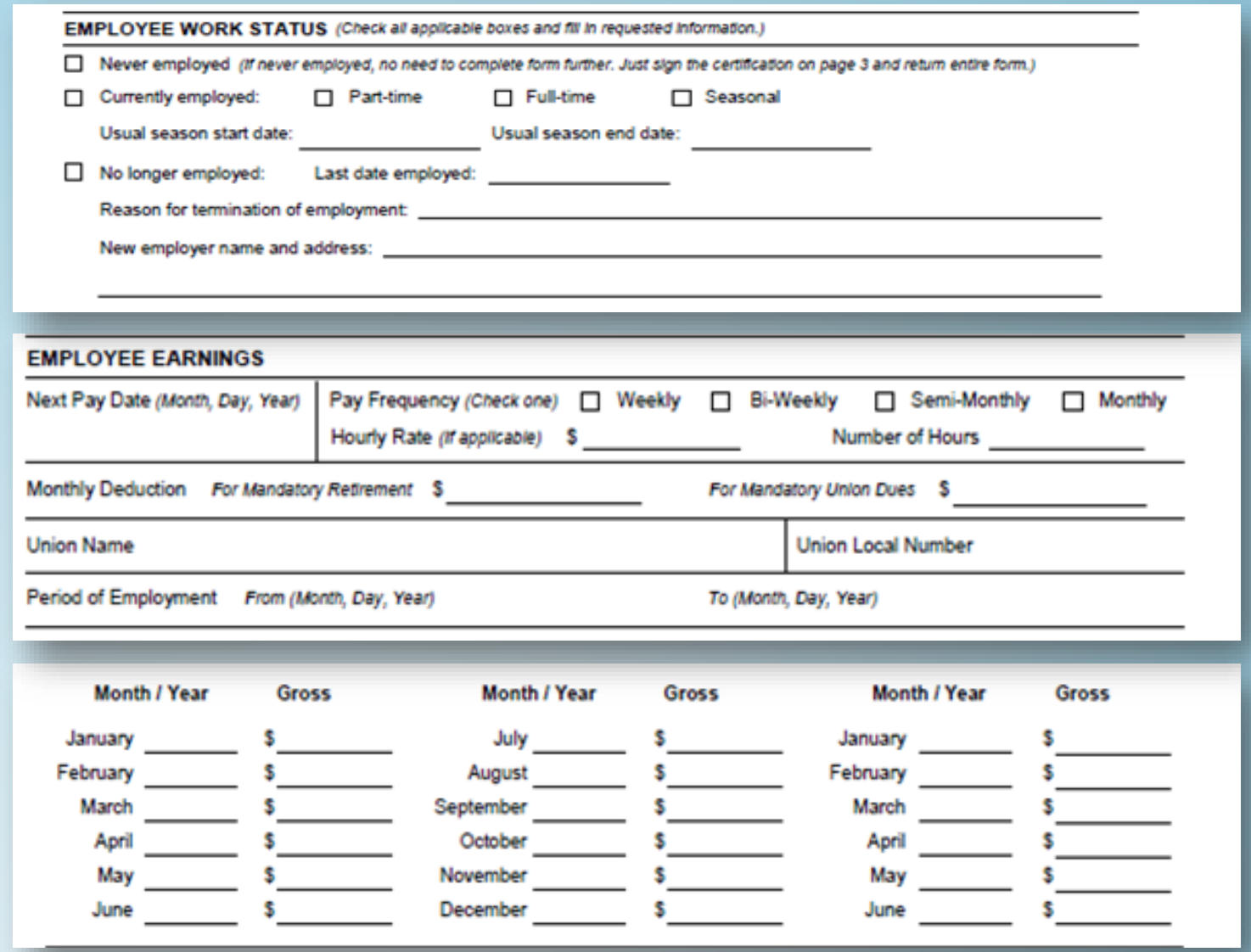
POST 5

Wage Verifications

Employee work status, start date, termination date and reason

Pay date, hourly rate, mandatory retirement, and union dues

Employee's earnings for the past 12 months



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 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* $ _____

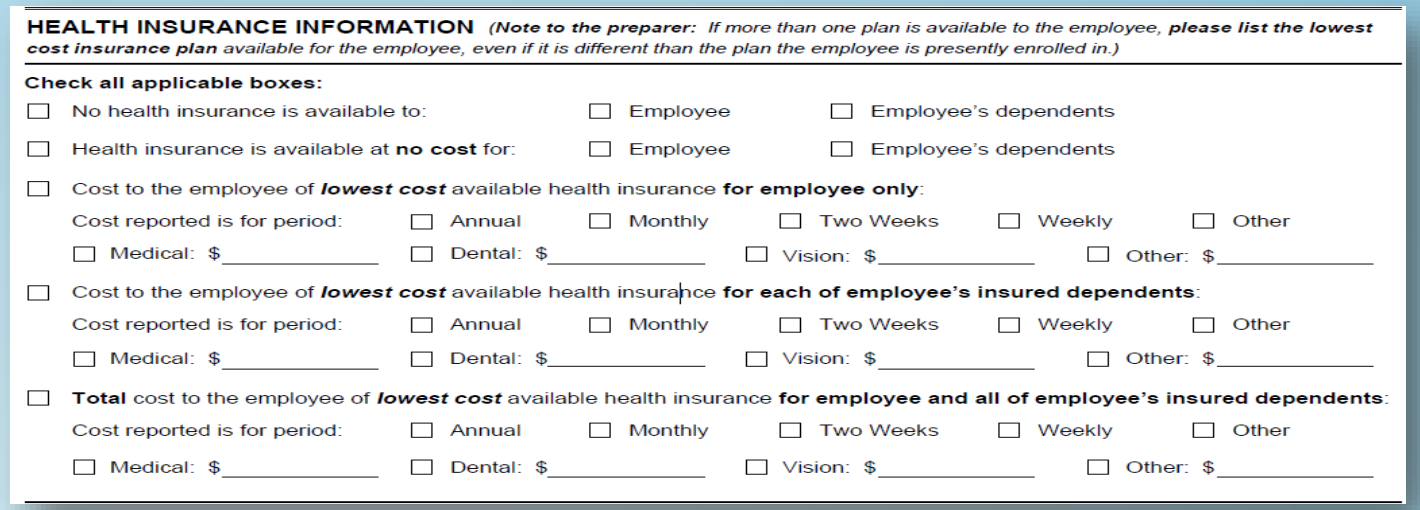
Union Name | Union Local Number

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

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	$

Insurance Verifications

Health insurance coverage costs for medical, dental and vision



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

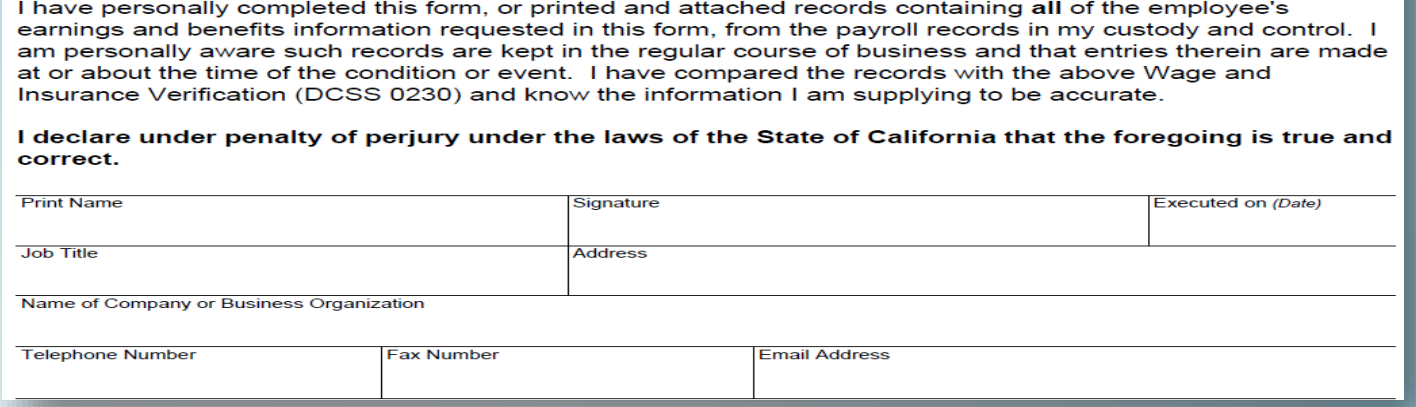
☐ Medical: $_____ ☐ Dental: $_____ ☐ Vision: $_____ ☐ Other: $_____

☐ **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: $_____

Contact information for company payroll/HR representative



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

Income Withholding Orders **(IWO)**
Electronic Income Withholding Orders **(e-IWO)**

Brandon Felix

Contra Costa County

Poll Time!

Are you currently signed up for e-IWO?

Income Withholding Orders

IWOs are **mandated**, not discretionary

Employer responsibilities:

- Withhold the specified amount
- Remit timely payments
- Send payments to the State Disbursement Unit (SDU)
- Honor IWO until **amended or terminated**
- **Keep IWO on file for one year** after separation of employment
- Employees cannot "opt out"

Processing Timeframes

- Within **10 days** of receipt, notify and provide a copy of the IWO and the *Request for Hearing Regarding Earnings Assignment* to your employee

- Within **10 days** of receipt, begin withholding the first pay period following the *remittance date* found at the top of page 4

- Remit payments within **7 days** of withholding

Importance of Timely Processing

Credit for payment is 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

Request for Hearing Regarding Earnings Assignment

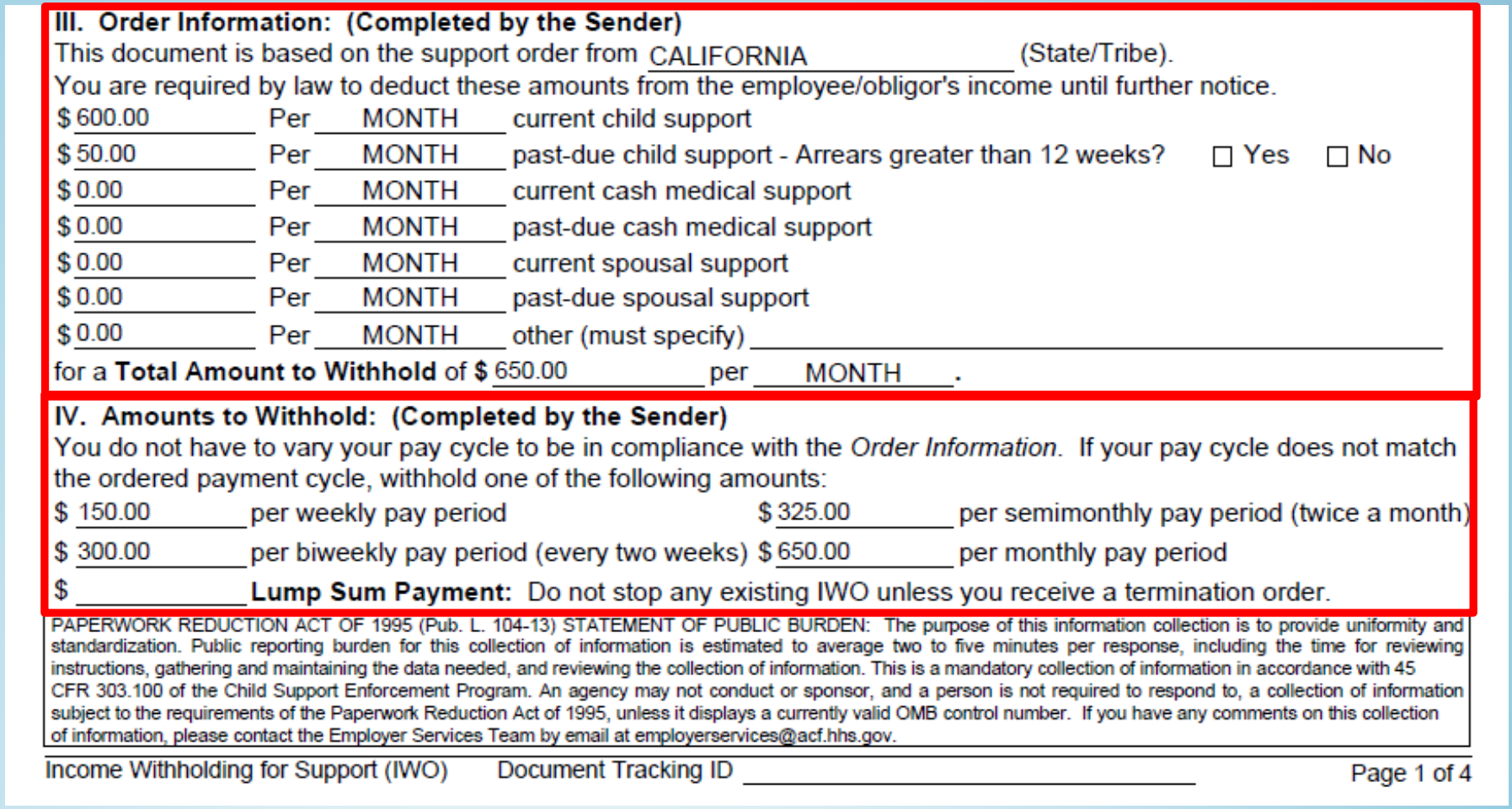
FL-450

ATTORNEY OR PARTY WITHOUT ATTORNEY *(Name, State Bar number, and address):*	*FOR COURT USE ONLY*
20000000 TELEPHONE NO.: FAX NO. *(Optional):* E-MAIL ADDRESS *(Optional):* ATTORNEY FOR *(Name):*	Page 11 of the IWO
SUPERIOR COURT OF CALIFORNIA, COUNTY OF STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME:	
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.

Order Information

- You do **not** need to change your payroll cycle to adjust to the child support deductions



III. Order Information: (Completed by the Sender)

This document is based on the support order from CALIFORNIA (State/Tribe).

You are required by law to deduct these amounts from the employee/obligor's income until further notice.

$ 600.00	Per MONTH	current child support	
$ 50.00	Per MONTH	past-due child support - Arrears greater than 12 weeks?	☐ Yes ☐ No
$ 0.00	Per MONTH	current cash medical support	
$ 0.00	Per MONTH	past-due cash medical support	
$ 0.00	Per MONTH	current spousal support	
$ 0.00	Per MONTH	past-due spousal support	
$ 0.00	Per MONTH	other (must specify)	

for a **Total Amount to Withhold** of $ 650.00 per MONTH .

IV. Amounts to Withhold: (Completed by the Sender)

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:

$ 150.00	per weekly pay period	$ 325.00	per semimonthly pay period (twice a month)
$ 300.00	per biweekly pay period (every two weeks)	$ 650.00	per monthly pay period
$	**Lump Sum Payment:** Do not stop any existing IWO unless you receive a termination order.		

PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13) STATEMENT OF PUBLIC BURDEN: The purpose of this information collection is to provide uniformity and standardization. Public reporting burden for this collection of information is estimated to average two to five minutes per response, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. This is a mandatory collection of information in accordance with 45 CFR 303.100 of the Child Support Enforcement Program. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information subject to the requirements of the Paperwork Reduction Act of 1995, unless it displays a currently valid OMB control number. If you have any comments on this collection of information, please contact the Employer Services Team by email at employerservices@acf.hhs.gov.

Income Withholding for Support (IWO) Document Tracking ID _____ Page 1 of 4

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

Employee Status Change

Separation of employment

or

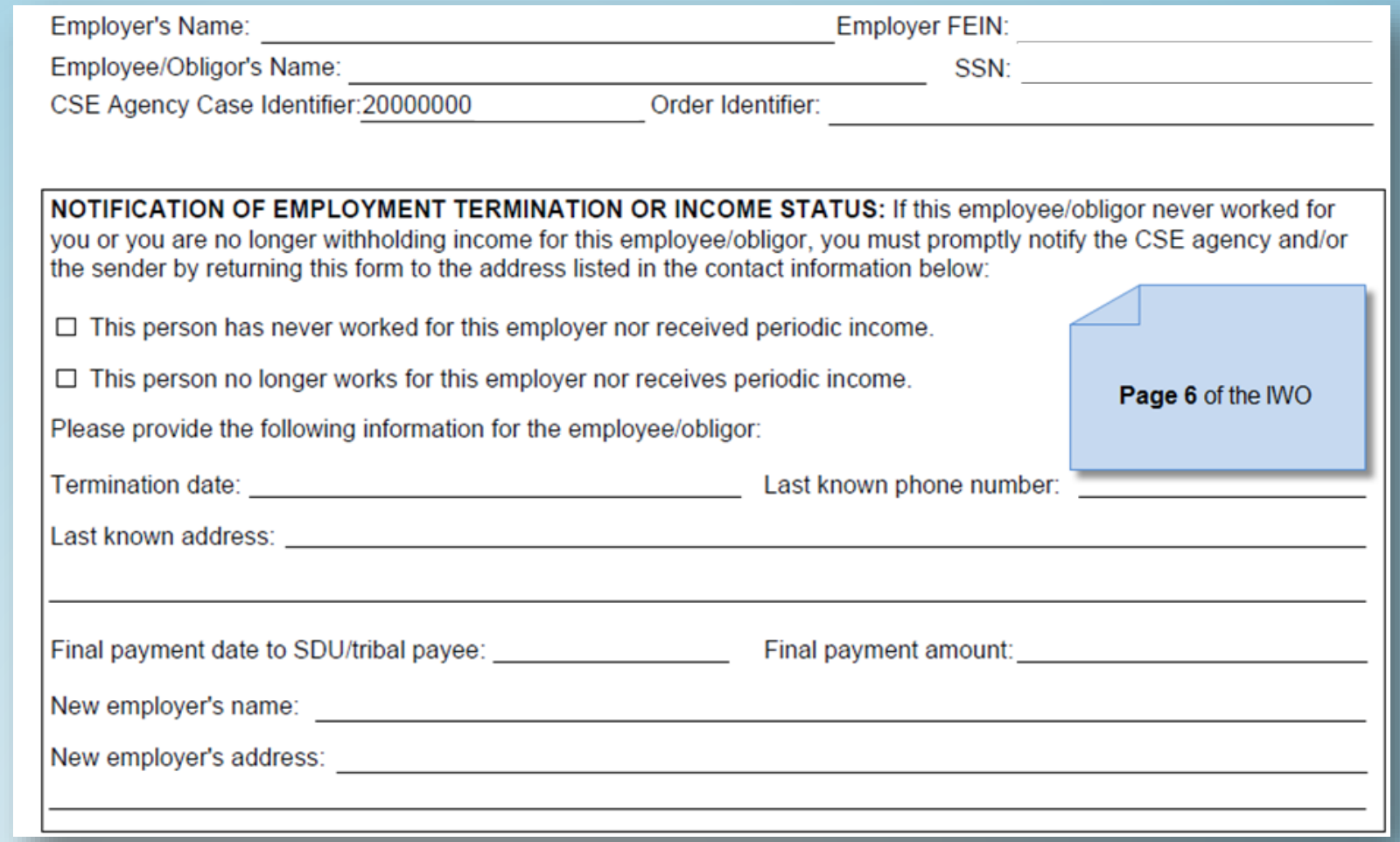
Change of work status

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

Notification of Employment Status

Report by phone at:
(866) 901-3212



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

DCSS Form 0522
online at
www.childsupport.ca.gov

CSE Case Number:
Noncustodial Parent:

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).

Bonus & Lump Sum IWOs

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

These payments made to employees include:

- Bonuses
- Vacation payouts
- Commissions
- Severance or buy-out payments
- Retroactive pay increases
- Sign on bonuses
- Cash awards
- Incentive payments
- Retirement incentives

Privately Issued IWOs

- Upon receipt, make a copy and retain original
- Send copy to the SDU (FL-195 Case Registry Form)
- The 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

What is an e-IWO?

- Receive Income Withholding Orders (IWOs)
- Send Acknowledgement of Acceptance or Rejection of IWOs
- Notification of employee receiving a Bonus/Lump Sum payment
- Notification of employee terminations

Benefits of e-IWO

- One time enrollment
- Child support gets to the families sooner
- Saves time, money, and resources
- Ensures uniform IWO data from all states
- Increases accuracy and reliability of data
- No cost to employers

e-IWO System Options

- **System-to-System Interface**
  - 4 – 5 months
  - High volume

- **No Programming Option**
  - 2 – 4 weeks
  - Low volume

For more Information visit:
https://www.acf.hhs.gov/css/employers/e-iwo

To sign up via email:
eIWOmail@acf.hhs.gov

Withholding Limitations and Deductions

Defining Earnings

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

- Wages/salary
- Bonuses/commissions
- Vacation pay
- Retirement
- Dividends, royalties, and residuals
- Payment for independent contractors or 1099 employees

Withholding Limitations

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

- If all IWOs are CA agency child support obligations and the total exceeds 50% of net, withhold 50% and send to the CA SDU

- SDU will divide funds based on Federal hierarchy

Determining Net Disposable Income (NDI)

Gross Income		**$5,000**
State Income Tax	($500)	
Federal Income Tax	($120)	
FICA	($330)	
Medicare	($75)	
SDI	($55)	
Mandatory Union Dues	($60)	
Mandatory Retirement	($150)	
Net Disposable Income		**$3,710**
		x 0.5
Available for Deduction		**$1,855.0**

***Do NOT include voluntary deductions**

Priority of Withholding

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

* only if levy was in place *before* child support order was entered

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

Call us at **(866) 901-3212** with questions

Multiple Orders from Different States

Payee	Current support obligations	Obligation/Total	Amount paid on order (NDI is $360 maximum deduction is $180)
CA	$90	$90/$227 = 39.65%	$180 x 39.65% = $71.37
AZ	$75	$75/$227 = 33.04%	$180 x 33.04% = $59.47
TX	$62	$62/$227 = 27.31%	$180 x 27.31% = $49.16
Total	$227	100%	$180

Remitting Payments

Kanisha George

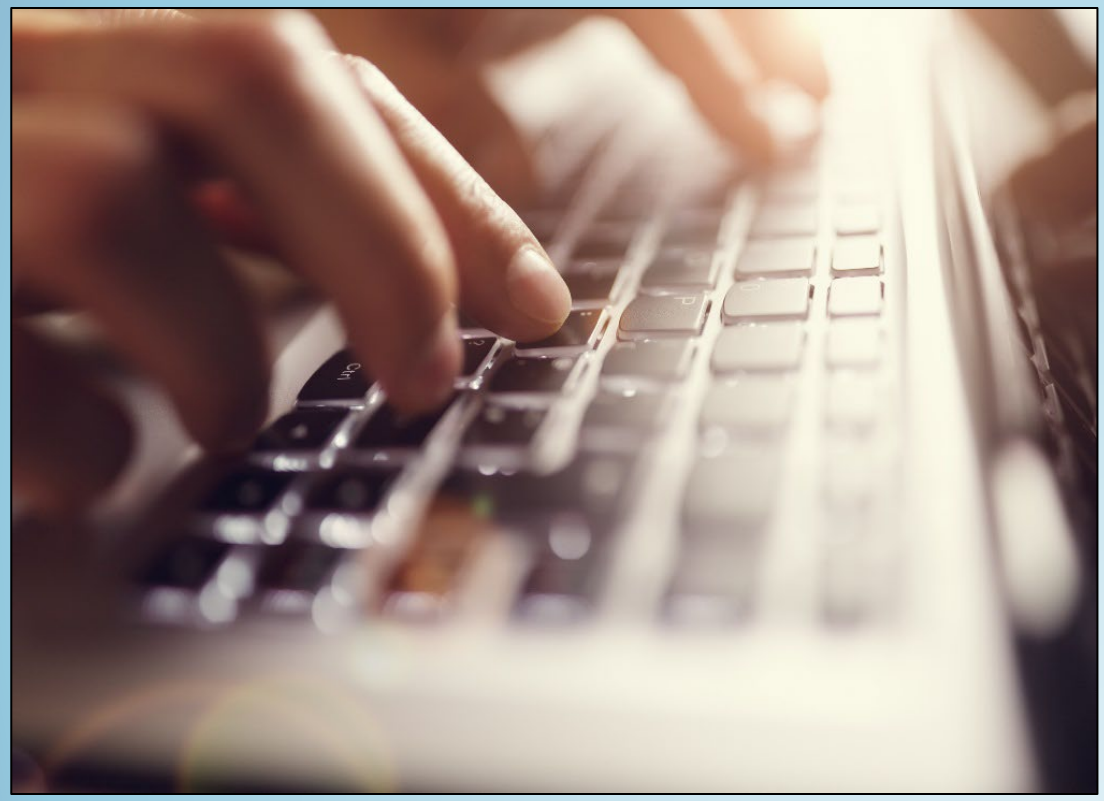
Santa Clara County

Payment Options

Pursuant to California Family Code §17309.5 -

If an employer pays taxes electronically to the Franchise Tax Board (FTB) or the Employment Development Department (EDD), then child support payments are required to be sent to the State Disbursement Unit (SDU)using Electronic Funds Transfer (EFT).

Electronic Payment Benefits



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

Electronic Payment Options

- Make electronic payments using the ACH Debit, Credit Card and PayPal options using ExpertPay at **http://www.expertpay.com**

- Automated Clearing House Credit:
  Contact the CA SDU electronic help desk at (866) 901-3212 (option 1) or email **casdu-electronichelpdesk@dcss.ca.gov**

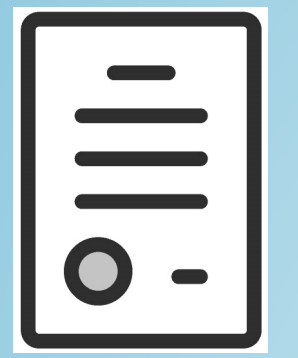
Payment Identification Information

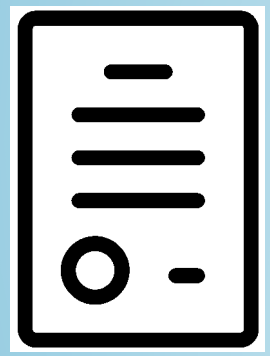
Include the following identifying information about your Employee(s):

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

Payment Remittance

Employee A, SSN #555 - $100





Employee B, SSN #777 - $150

Remit 1 payment - $250

SDU Matches Identifiers

Employee A's Family
$100

Employee B's Family
$150

SDU Mailing Address

Remitting Checks for Out-Of-State Employers

Mail check payments **only** to:
State Disbursement Unit
P.O. Box 989067
West Sacramento, CA 95798

Please do not mail payments directly the Local Child Support Agency.

Stop Payment Process

- **For payments by check:** Email the 'Employer Stop Payment Request' form to the CA SDU at CASDU.Stop.Request@conduent.com

- **For electronic payments**: Submit the 'Employer Refund Request' form to the CA Child Support Business Solutions Team by fax to (916) 636-2436 or via email at ccsasbusinesssolutions@dcss.ca.gov

Employers should **NOT** place stop payments on remitted payments until the SDU or the Business Solutions Team has been contacted.

For additional information visit: https://childsupport.ca.gov/employer-resource-center/employer-faqs/

Health Insurance and National Medical Support Notices (NMSNs)

National Medical Support Notice

- Health insurance must be provided to the employee's children even if the employee declines personal health coverage

- Not subject to open enrollment guidelines

- Complete the Health Insurance Information Form which can be found at:

https://childsupport.ca.gov/wp-content/uploads/sites/252/Employers/Health-Insurance-Information.pdf

Types of Insurance Coverage

- Medical
- Dental
- Vision care
- Prescriptions
- Mental health

Employer Responsibilities

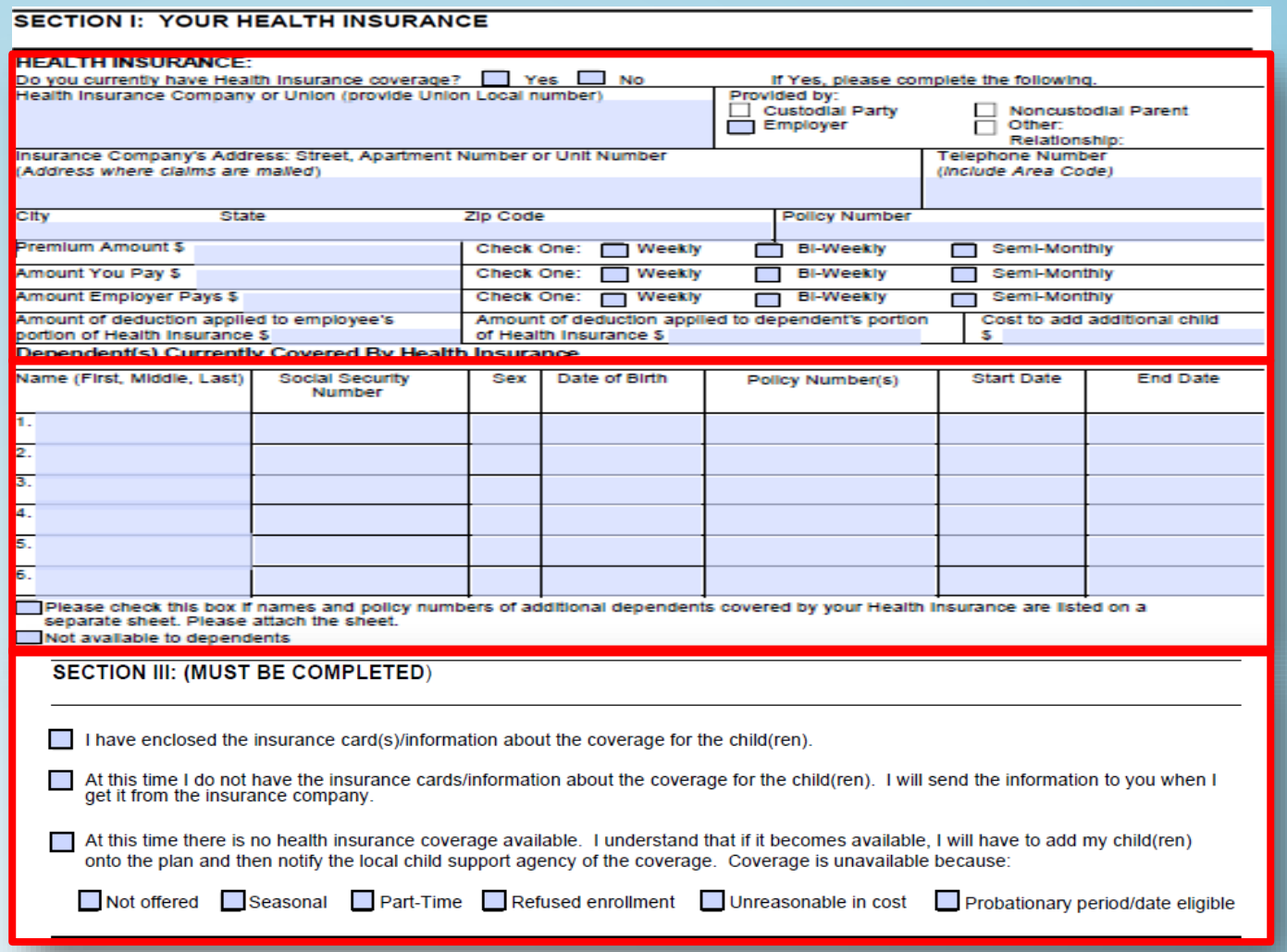
- Notify the employee within **10 business days** of receiving a NMSN
- If employee is no longer employed or health insurance is not available, complete items 1-5 on the Employer Response form and return to LCSA
- Within **20 business days,** employer must forward a copy of Part B Medical Support Notice to the health care plan administrator
- If employee is subject to a waiting period, notify the LCSA
- Within **40 business days**, provide the LCSA with a description of the coverage
- Withhold any employee contributions required
- Continue coverage until notified by the LCSA

Health Insurance Information Form

Please provide details and costs for medical, dental and vision

Coverage details for dependents

If Health Insurance is not available, please list the reason insurance coverage is not available



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)

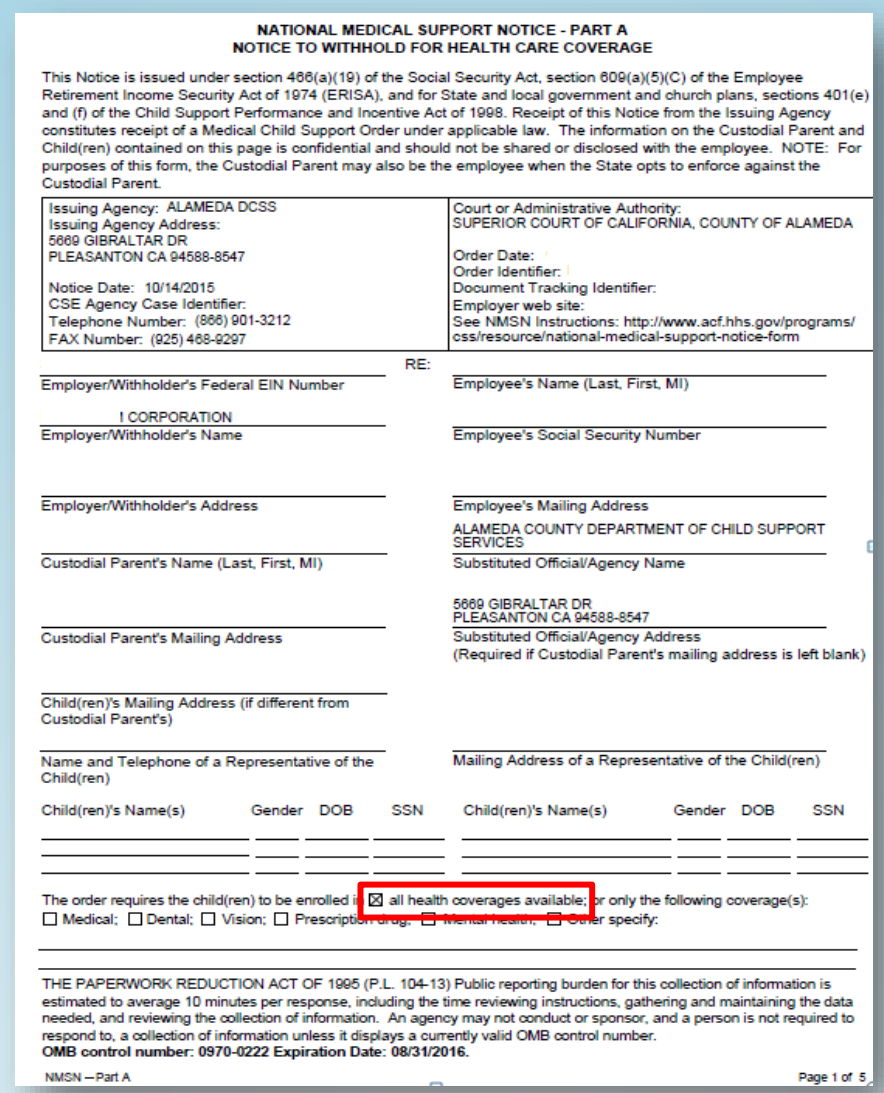
☐ I have enclosed the insurance card(s)/information about the coverage for the child(ren).

☐ 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

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/css/resource/national-medical-support-notice-form

RE:

Employer/Withholder's Federal EIN Number

Employee's Name (Last, First, MI)

I 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 i ☒ all health coverages available; or only the following coverage(s):
☐ Medical; ☐ Dental; ☐ Vision; ☐ Prescription drug; ☐ Mental health; ☐ Other specify:

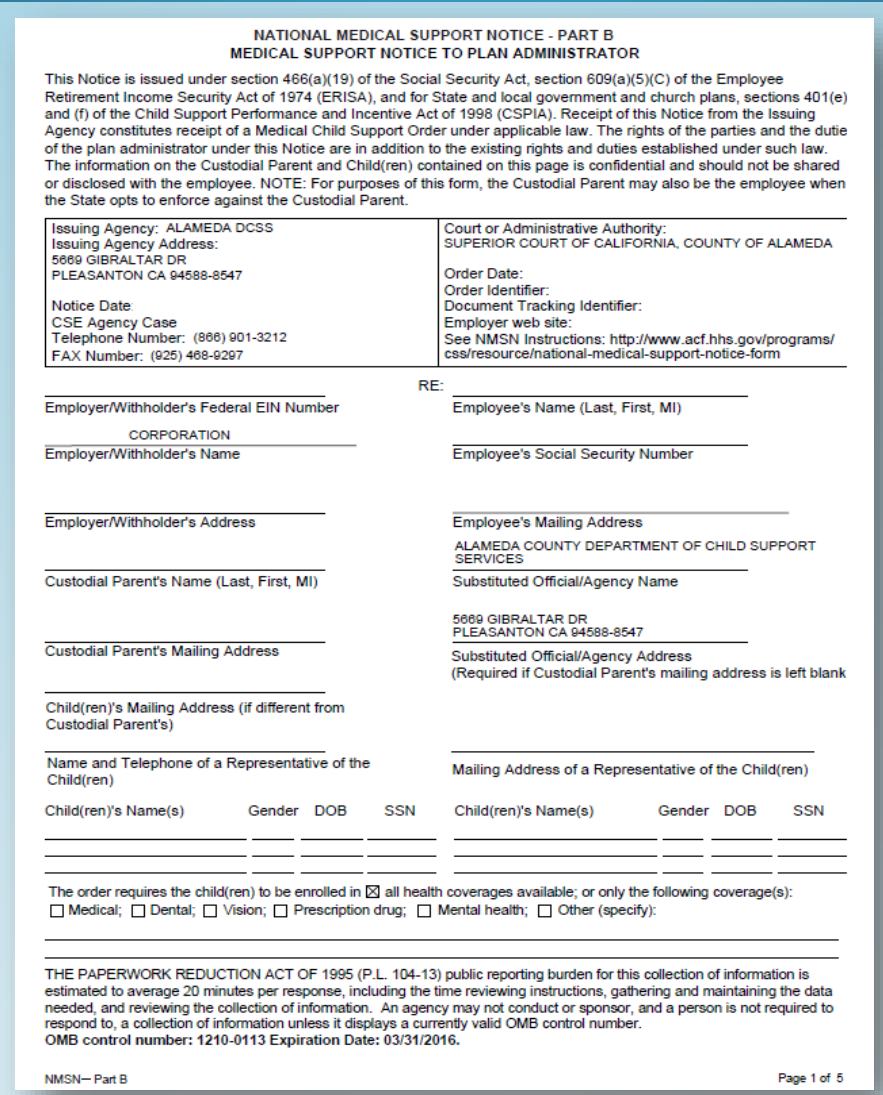
THE PAPERWORK REDUCTION ACT OF 1995 (P.L. 104-13) Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. An agency may 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 – Part A

Page 1 of 5

Within **20 Business Days** return Part A to the LCSA

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 dutie 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

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):

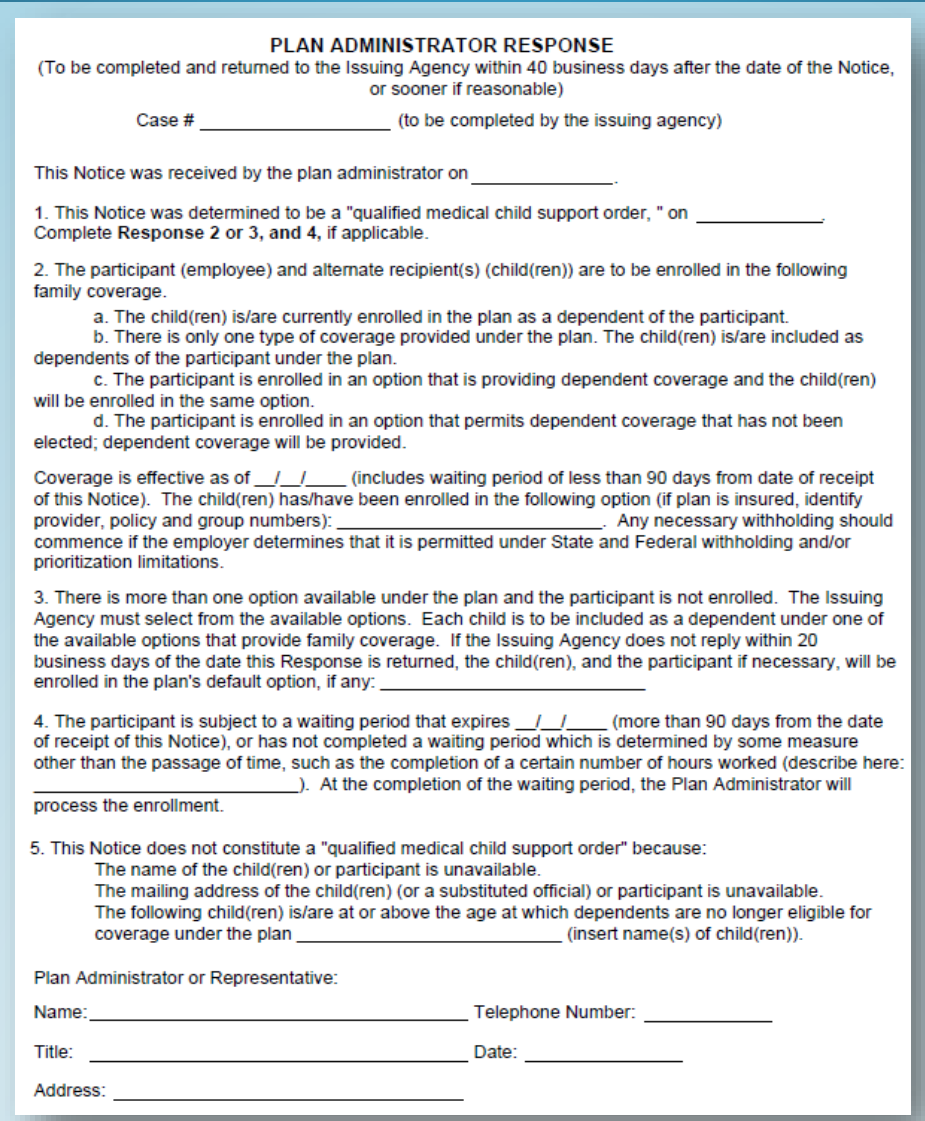
THE PAPERWORK REDUCTION ACT OF 1995 (P.L. 104-13) public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. An agency may 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– Part B

Page 1 of 5

Within **20 Business Days** forward Part B to your plan administrator if applicable

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: _____

Within **40 Business Days** complete the Plan Administrator Response section of Part B and return to the LCSA

Reasonable Health Insurance

Per California Senate Bill 580 "reasonable" cost of medical coverage is:

- The cost to add the child(ren) is not more than 5% of employee's gross income
- The total current support plus cost of coverage does not exceed 50% of employee's net disposable income
- The coverage provided must be within a 50-mile radius of the child's residence

Notify the LCSA if it appears any of these situations apply and we will make the final determination

Reasonable Health Insurance

Calculating 5% of Employee's gross income

Cost of Healthcare Plan Through Employer	
Employee only	$50
Employee and child	$150
Net difference in cost	**$100**

- We would use $100 when considering if the cost to add dependent healthcare is reasonable
- Compare the difference of $100 to the employee's gross income
- You cannot withhold more than 50% of the employee's net disposable income

Reporting Employee Separations

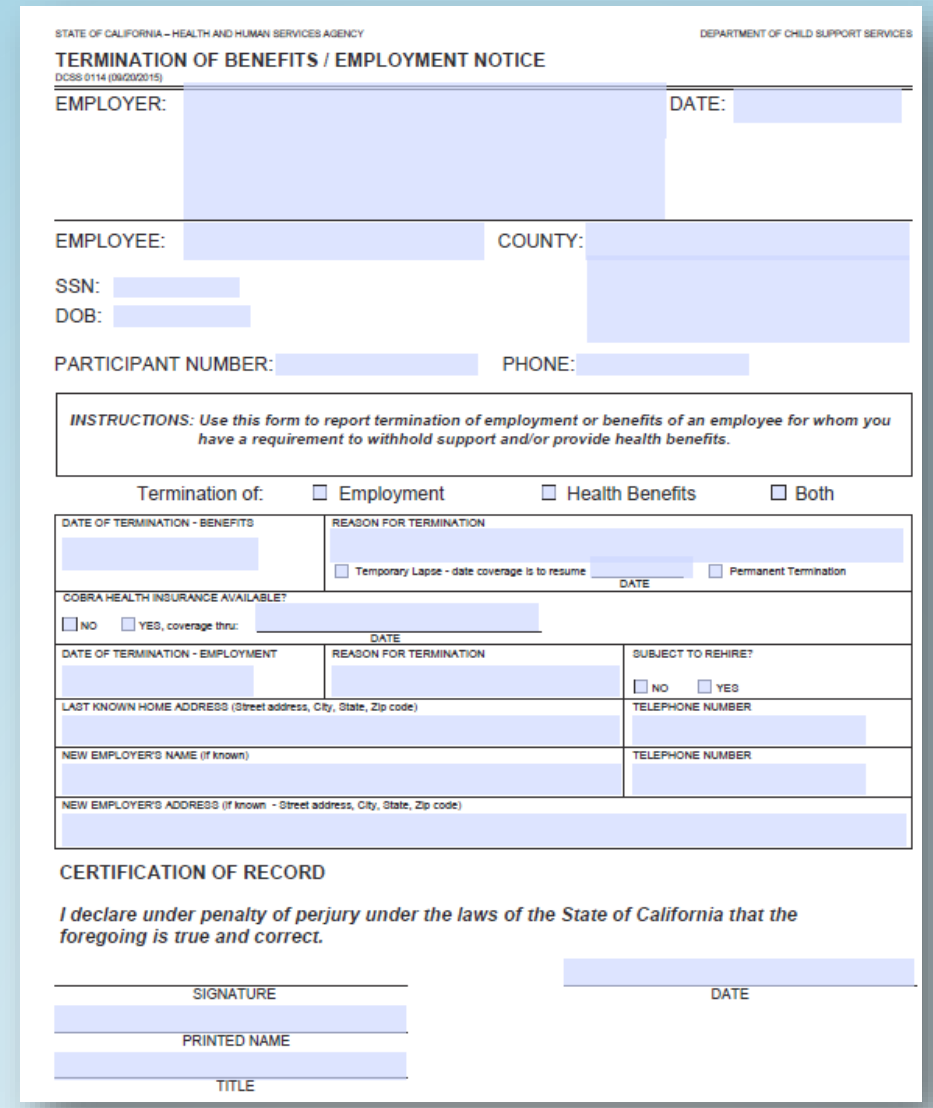
Notifying your LCSA when an employee separates employment

- Report terminated employees promptly by completing and returning the Termination of Benefits/Employment and Health Insurance Information which can be found at https://childsupport.ca.gov/wp-content/uploads/sites/252/Employers/Termination-of-Benefits.pdf

- Return notice to the issuing LCSA or contact them 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

www.childsupport.ca.gov

Stay Connected and Informed

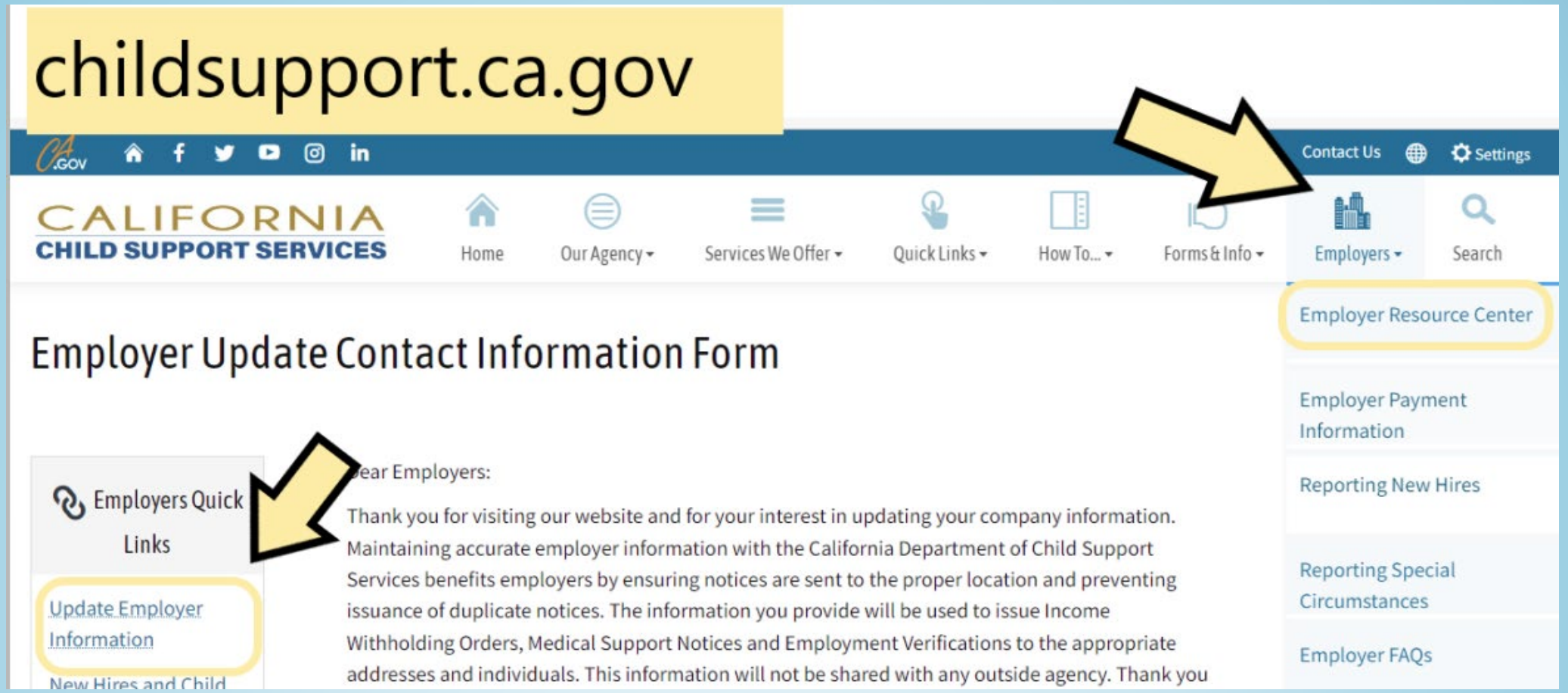
Caroline Castillo

Solano County

Update Your Information

Online:

childsupport.ca.gov



Employer Services Phone: 888-898-1743

Employer Resource Center

Employer Forms

To request versions accessible to persons with visual disabilities, click here.

- Employer Income Withholding Form (IWO)
- National Medical Support Notice Form
- Health Insurance Information
- Health Insurance Assignment Form / Instructions
- Termination of Benefits
- Employee Status Report
- Employer Refund Request
- Employer Stop Payment Request Form

Employer FAQs

Employers Quick Links

- Update Employer Information
- New Hires and Child Support
- Bonus/Termination Reporting
- Making Payments
- Employer FAQs
- Employer Workshops and Events
- Local Child Support Office Locations

We understand that there are many things about child support that are complicated and confusing. We are here to help you understand and navigate this process.

Below are answers to some of the most frequently asked questions by category:

Income Withholding Orders

Welcome to the Employer Resource Center!

In response to the Covid-19 national emergency, we are strongly encouraging employers to sign up to remit your child support payments electronically, to help eliminate potential delays in processing payments via paper check. Please see here for more information on your options.

As employers, you are one of our closest partners, with an important role in helping ensure families get the financial and medical support they need. More than 70% of all child support collections are through payroll deductions. Please note that maintaining accurate information about your company with California Child Support Services benefits you by making sure official notices reach the right destination and preventing duplication. You can update your company information here.

If you have an employee that is a member of a Native American tribe, you can find specialized information for withholding for these individuals here. If you have other questions or need assistance you can contact us at any time as we are here to better serve you.

Download the California Child Support Services Employer Handbook English

Employer Update Email List

Subscribe to the below Employer Update Email List to receive child support program information, Employer Outreach Event information, and helpful tips for employers.

Resources

California Child Support Services:	www.childsupport.ca.gov
California Employment Development Department (EDD): New Hire Information: Independent Contractor Information:	www.edd.ca.gov https://edd.ca.gov/Payroll_Taxes/New_Hire_Reporting.htm https://edd.ca.gov/Payroll_Taxes/Independent_Contractor_Reporting.htm
California State Disbursement Unit (SDU):	childsupport.ca.gov/state-disbursement-unit/
ExpertPay:	www.expertpay.com
Office of Child Support Enforcement (OCSE):	www.acf.hhs.gov/css https://www.acf.hhs.gov/css/employers/e-iwo

Poll Time!

How many phone numbers do you need to remember today ?

How to Reach Us

866-901-3212

childsupport.ca.gov/employer-resource-center/

bayareachildsupport.net

Visit the Employer Resource Center for more information


Thank You

EXPERT PANEL

Kimberly Brower – Contra Costa County

Elizabeth Ryan – Sonoma County

Janet Nottley – Napa County

Jaime Magaña – Napa County

Angela Jones – State DCSS

Randy Ginise – EDD

Questions?

Closing

Karen Roye

Director, San Francisco DCSS