Welcome

Ignacio J. Guerrero

Director, Santa Clara County
Department of Child Support Services

2026 Employer Workshop

Poll Time

What are your biggest challenges relating to child support processes?

Agenda

- Reporting New Hires and Wage & Insurance Verifications
- Income Withholding Orders/ e-IWO
- Bonus & Lump Sum Income Reporting/Lump Sum IWO Processing
- Remitting Payments
- Health Insurance & National Medical Support Notices
- Employment Changes
- Live Panel Discussion and Question & Answer Session
- Closing Remarks

Learning Objectives

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

Structure of the Program

OFFICE OF CHILD SUPPORT SERVICES

An Office of the Administration for Children & Families

CALIFORNIA
CHILD SUPPORT SERVICES

California State Disbursement Unit

Local Child Support Agency

State, SDU, and LCSA

CA CSS

- Non-agency customer service
- Employer verification services

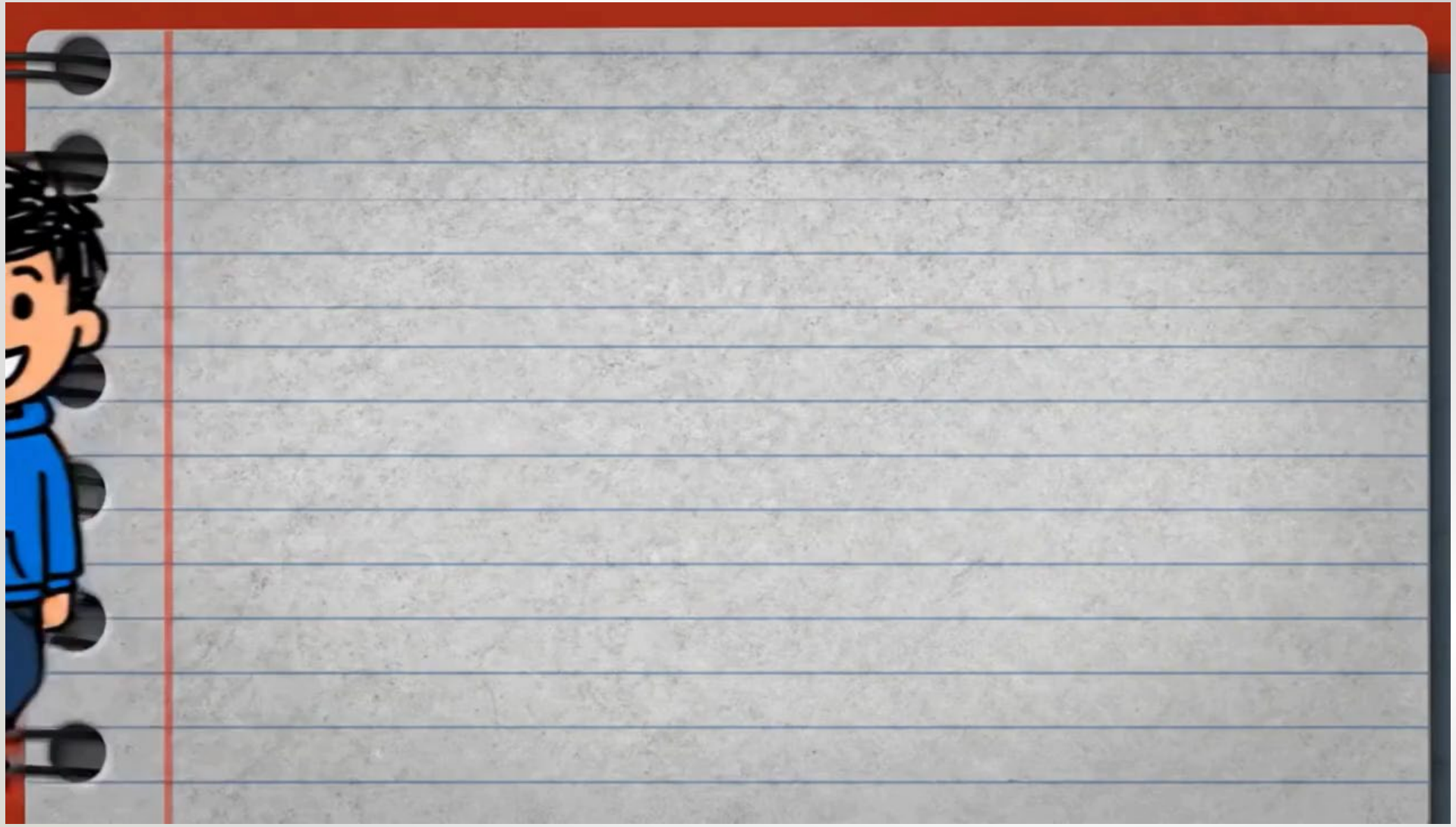
SDU

- Collection processing
- Electronic help desk
- Stop payments
- Non-sufficient funds

LCSA

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

Employee-JOHN



Reporting New Hires and Wage & Insurance Verifications

Scott Tamanaha

Monterey County

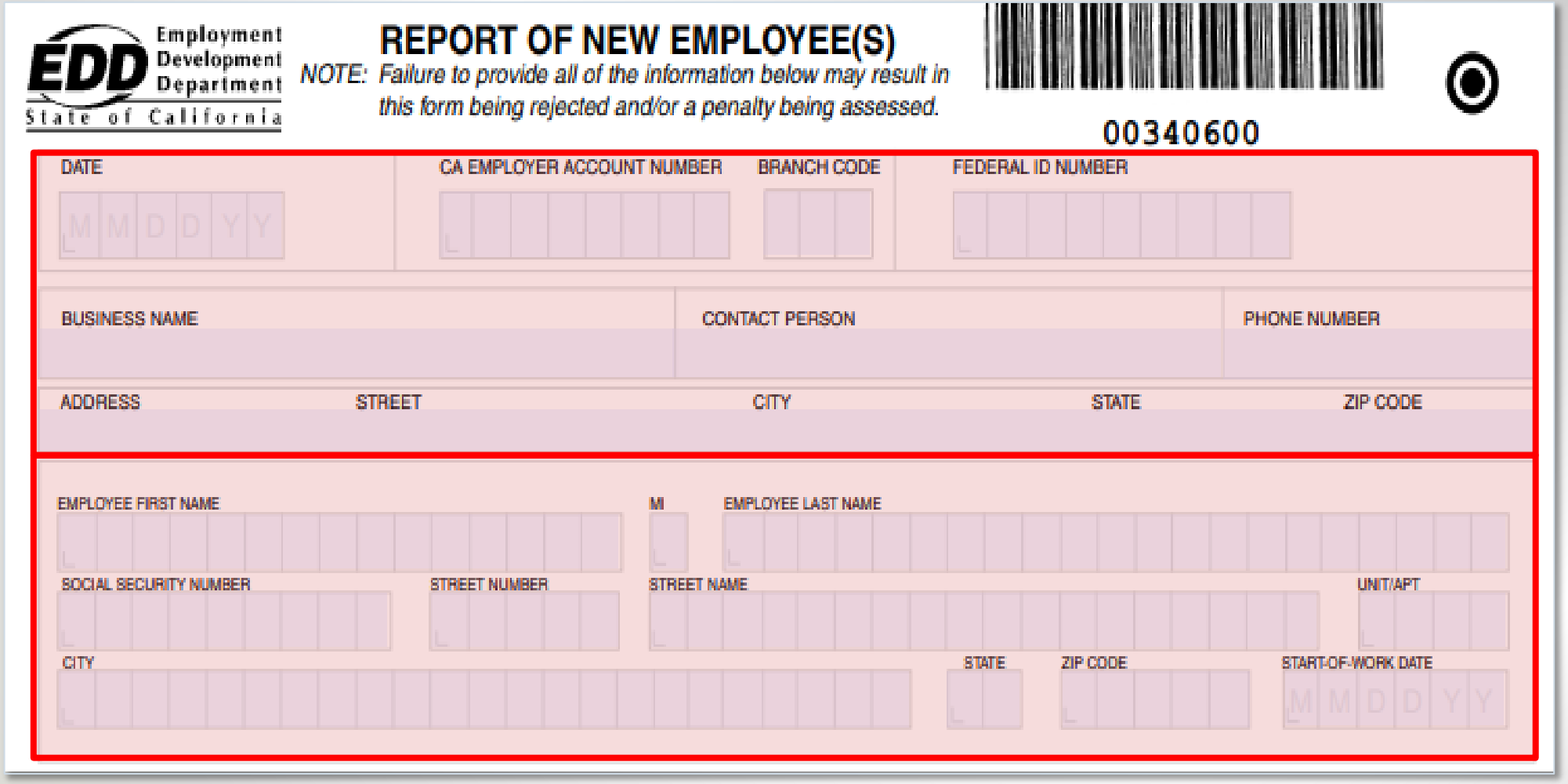
New Hire Reporting Guidelines

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

New Hire Reporting Forms

Employer Information

Employee Information



EDD Employment Development Department
State of California

REPORT OF NEW EMPLOYEE(S)

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

00340600

DATE (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

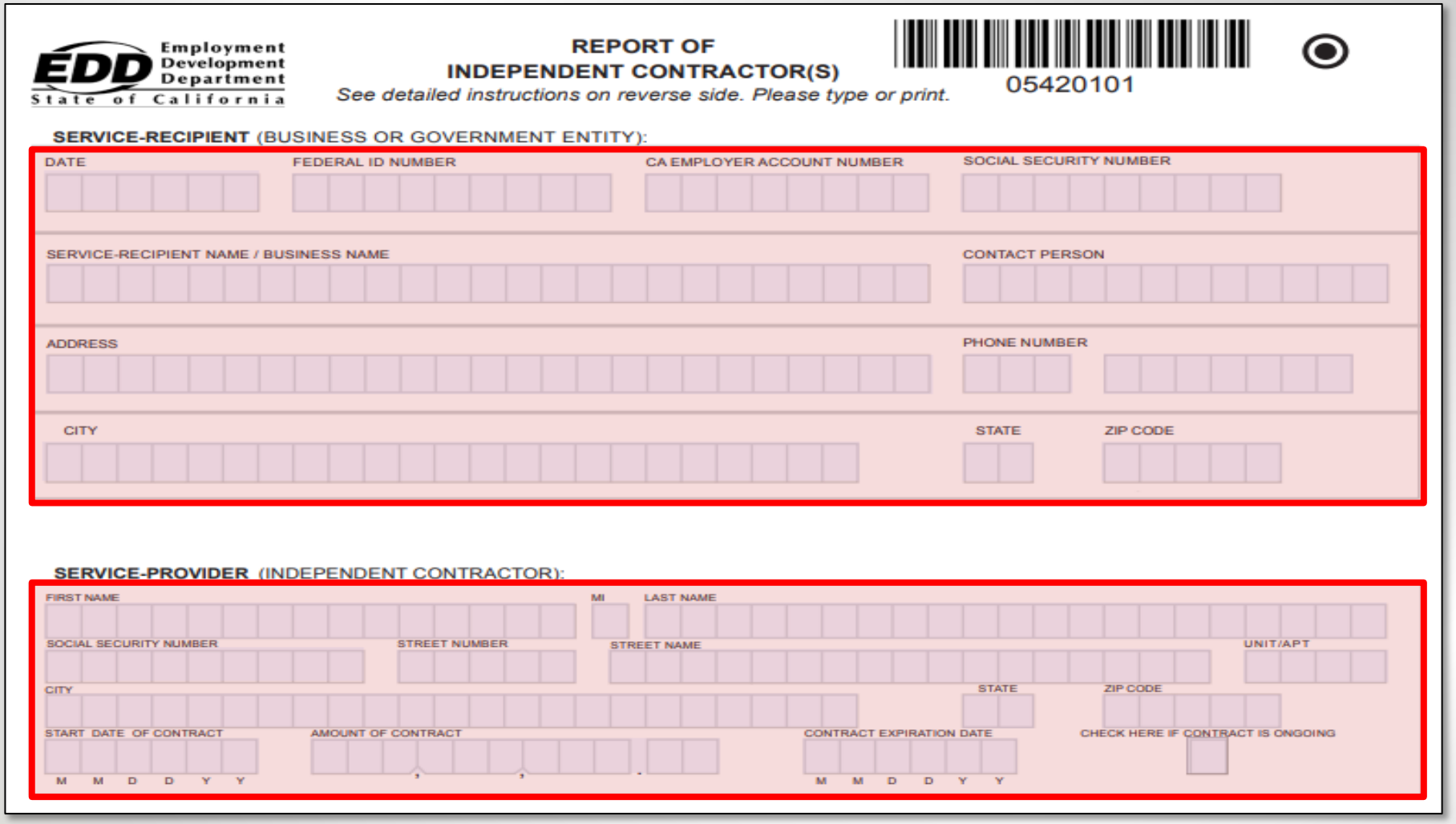
START-OF-WORK DATE (MMDDYY)

EDD Form DE 34 for New or Rehired Employees

Independent Contractor Reporting Form

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

EDD Form DE 542 for Independent Contractors

New Hire Reporting Options

- **Online** e-Services for Business **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: 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.

Employee-JOHN

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 (12/15/2024)

CSE Case Number:
Participant Name:
Employer Name:

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

Name:	Social Security Number:	Date of Birth:
Address:		Phone Number:

REQUIRED INFORMATION

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: _____
☐ **Independent Contractor** Usual season end date: _____

Occupation:

☐ **No longer employed:** Last date employed:

Wage Verifications

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

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

HEALTH INSURANCE INFORMATION (Note to the preparer: If more than one plan is available

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	Email Address	
Fax Number	FEIN (Do not provide SSN)	

Knowledge Checkpoint

Who should be reported to the National Directory of New Hires?

Employee-JOHN

Income Withholding Orders **Basics**

Dora Muro

Sonoma County

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.

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

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

e-IWO Online

- 5 – 15 days
- No server required

For more Information visit:

acf.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 recipients

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

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

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

Poll Time!

Are you currently signed up for e-IWO?

Remitting Payments

Nancy Anaya-Zamora

Santa Cruz/San Benito County

SANTA CRUZ
REGIONAL
SAN BENITO
DEPARTMENT OF CHILD SUPPORT SERVICES

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 **expertpay.com**

ExpertPay℠

Automated Clearing House Credit:

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

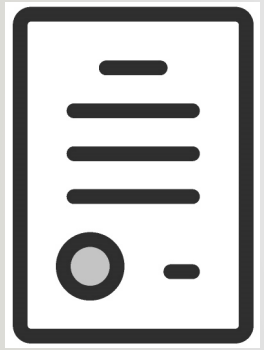
Payment Identification Information

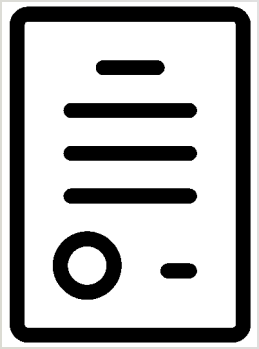
Include the following identifying information about your Employee(s):

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

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:** Complete the Employer Stop Payment Request form online at **dcss.ca.gov/employer-forms/**

- **For electronic payments**: Submit the 'Employer Refund Request' form found at **dcss.ca.gov/employer-forms/**

Employers should **NOT** place stop payments on remitted payments until contacted.

- For additional information visit: **dcss.ca.gov/employer-resource/**

Knowledge Checkpoint

It is required that the employer remit child support deductions via Electronic Funds Transfer (EFT) when they remit payroll taxes electronically.

True
Or
False

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 National Medical Support Notice Form Part B

Types of Insurance Coverage

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

Employer Responsibilities

Within **10 business days** of receiving the NMSN you must notify your employee

Complete the Employer Response form on the NMSN Part A and return this LCSA within **20 business days**

Within **20 business days** of receiving the NMSN, you must forward the Part B Medical Support Notice to the health care plan administrator

If employee is subject to a waiting period such as a probationary period, notify the LCSA

Employer Responsibilities

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

NMSN Form– Part A

New NMSN or Termination

LCSA Sending the NMSN

Jurisdiction of the Court that issued the Order

What coverage to enroll in

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 have policies to enforce against custodial parents.

☒ **National Medical Support Order/Notice (NMSN)** ☐ **Termination Order/Notice - if checked, see page 2**

Notice Date: Issuing Agency: Address: **Case Identifier**: Telephone Number: (866) 901-3212 Email Address: FAX Number:	Court or Administrative Authority: SUPERIOR COURT OF CALIFORNIA, COUNTY OF Order Date: Order Identifier: Document Tracking Identifier: Employer website: See NMSN Instructions: https://acf.gov/sites/default/files/documents/ocse/omb_0970-0222_a_instructions.pdf

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:

NMSN Form– Part A

EMPLOYER RESPONSE

Section 1 - No Enrollment Possible

The employer knows that the plan administrator cannot enroll dependents in employer-provided health care coverage for the employee named on page 1 because:

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

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

☐ 3. The employee is among a class of employees (for example, part-time or non-union) that are not eligible for family health care coverage under any group health care plan maintained by the employer or to which the employer contributes. **If the employee is only temporarily ineligible for health care coverage, do not check this box, and advance to Section 2.**

☐ 4. Health care coverage is not available because employee is not employed by employer:

Effective date of separation: _____

Reason for separation: _____

Last known telephone number: _____

Last known address:

Address line 1: _____

Address line 2: _____

Address line 3: _____

City: _____ State: _____ ZIP Code: _____ ZIP Code Ext: _____

(If new employment information is known, add at #6).

☐ 5. State or Federal withholding limitations and/or prioritization prevent the withholding from the employee's income of the amount required to obtain coverage under the terms of the plan. (See page 2 for description and instructions.)

☐ 6. Other (new job information for employee, child adequately covered by third party, other reason for no coverage):

New employer (if known): _____ New employer telephone number: _____

New Employer Address:

Address line 1: _____

Address line 2: _____

Address line 3: _____

City: _____ State: _____ ZIP Code: _____ ZIP Code Ext: _____

Section 2 - Dependent Enrollment Not Yet Available

☐ 7. 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.

☐ 8. Employee is on an unpaid leave of absence. Expected date of return: _____

Section 3 - Dependent Coverage Available

☐ 9. Employer forwarded Part B - Medical Support Notice to Plan Administrator on this date: _____

NMSN Form– Part B

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

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 have policies to enforce against the Custodial Parent.

NMSN Form– Part B

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

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 this date_____.

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

☐ 2.The participant (employee) and alternate recipient(s) (child(ren)) are or will 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, provider, policy and group numbers, and addresses for submitting claims, are provided in Addendum Section 1). Any necessary withholding should commence if the employer determines that it is permitted under State and Federal withholding and/or prioritization limitations.

NMSN Form– Part B

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

☐ 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: _____ (if plan is insured, see Addendum Section 1.)

☐ 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.

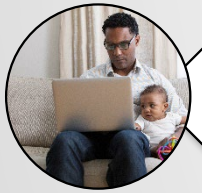
☐ 5.This Notice does not constitute a "qualified medical child support order" because:

- ☐ 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 child(ren) identified in the Addendum Section 2 is/are at or above the age at which dependents are no longer eligible for coverage under the plan.

Reasonable Health Insurance

California SB 580 defines "Reasonable" cost as:

Costs to add child is no more than 5% of employee's gross income



Total cost of support plus cost of insurance does not exceed 50% of employee's net income

Coverage provider must be within 50 miles of child's residence

If employee is questioning the NMSN, refer them to the LCSA

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**

- You would ask – is $100 more than 5% of employee's gross income
- You cannot withhold more than 50% of the employee's net disposable income

Employment Status Changes

Reporting Employee Separations

Notification Options:

- Complete the "Notification of Employment Termination or Income Status"
- Complete the "Employer Response"
- Complete the "Employee Status Report"
- Complete the "Termination of Benefits/Employment Notice"
- Return notices 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 by email: **employerservices@acf.hhs.gov**

Notification of Employment Status

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.

Page 6 of the IWO

Please provide the following information for the employee/obligor:

Termination date: _____ Last known phone number: _____

Last known address: _____

_____

Final payment date to SDU/tribal payee: _____ Final payment amount: _____

New employer's name: _____

New employer's address: _____

_____

Or report by phone at: **(866) 901-3212**

Employer Response – Section 1

EMPLOYER RESPONSE

Section 1 - No Enrollment Possible

The employer knows that the plan administrator cannot enroll dependents in employer-provided health care coverage for the employee named on page 1, because: (select all that apply)

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

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

☐ 3. The employee is among a class of employees (for example, part-time or non-union) that are not eligible for family health care coverage under any group health care plan maintained by the employer or to which the employer contributes. **If the employee is only temporarily ineligible for health care coverage, do not check this box, and advance to Section 2.**

☐ 4. Health care coverage is not available because employee is no longer employed here:

Effective date of separation: _____

Reason for separation: _____

Last known telephone number: _____

Last known address: _____

(If new employment information is known, add at #6).

Or report by phone at: **(866) 901-3212**

Employee Status Report

DCSS Form 0522
online at
dcss.ca.gov/employer-forms/

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:

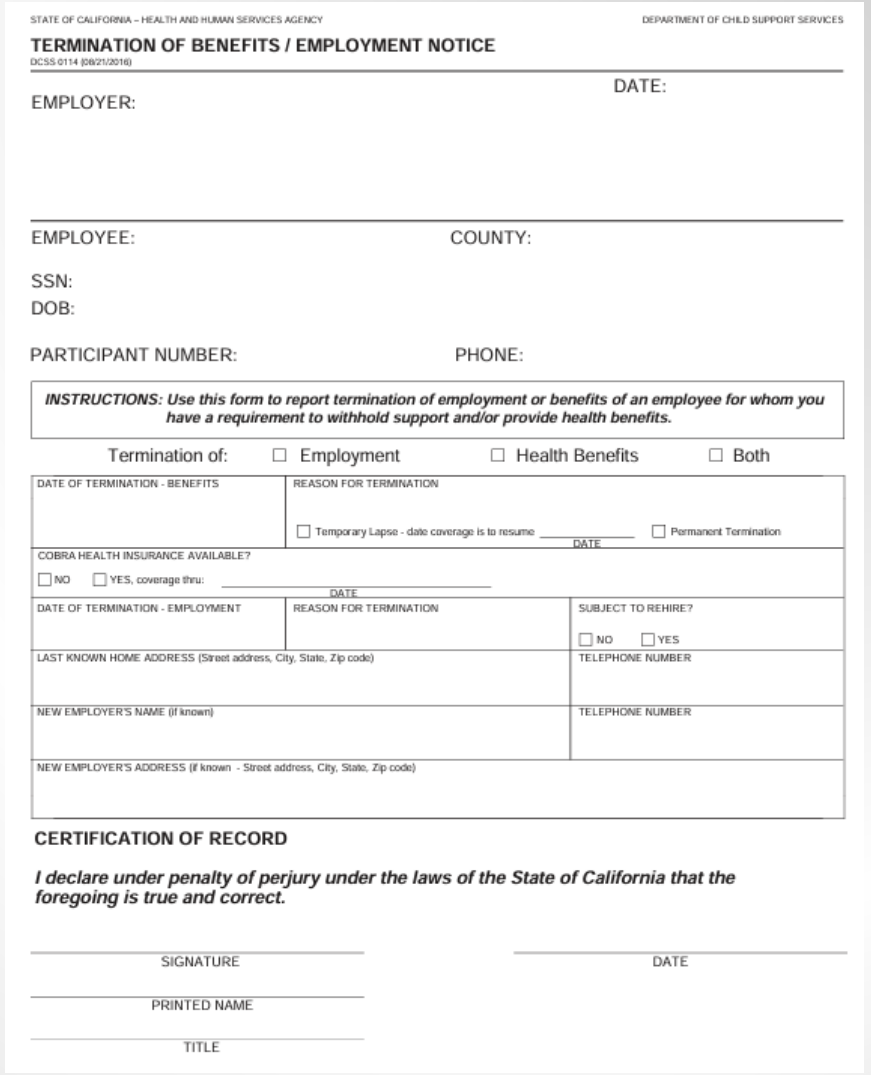
1. ☐ We received the IWO regarding the employee named above on _____ (Date).
2. ☐ The employee named above is presently employed. The withholding will begin on _____ (Date).
3. ☐ Our payroll is issued: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Twice a month on _____ (Date).
4. ☐ On _____ (Date), the above employee:
   ☐ 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).

Or report by phone at: **(866) 901-3212**

Termination of Benefits/Employment Notice

DCSS Form 0114
online at
dcss.ca.gov/employer-forms/

Or report by phone at: **(866) 901-3212**



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

TERMINATION OF BENEFITS / EMPLOYMENT NOTICE

DCSS 0114 (09/21/2016)

DATE:

EMPLOYER:

EMPLOYEE: COUNTY:

SSN:

DOB:

PARTICIPANT NUMBER: PHONE:

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

Termination of: ☐ Employment ☐ Health Benefits ☐ Both

DATE OF TERMINATION - BENEFITS	REASON FOR TERMINATION ☐ 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

Knowledge Checkpoint

The cost of medical coverage is deemed reasonable if?

- The cost is less than 5% of the employee's gross income
- The cost is less than 5% of the employee's net income

EXPERT PANEL

Cindy Delgado – San Mateo County

Wendy Solorio – San Benito County

Shawna Smith – State DCSS

Resources

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

Employer Resource Center

Employer Forms

Please Note

To submit a form via email, users must first download the form to their device and then click "submit" on the completed form.

To request an accessible version of any of these forms, please complete this form.

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

Employer Frequently Asked Questions (FAQs)

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.

FAQ Categories

Click on any of the topics below to learn more

- Income Withholding Order (IWO)
- Electronic Income Withholding Order (e-IWO)
- Making Payments
- California State Disbursement Unit (SDU)
- Payment Options
- Reporting New Hires
- Reporting Terminations
- Medical Support Order
- Updating Employer Information

Employer Handbook

Download the California Child Support Services Employer Handbook

Update Your Information

dcss.ca.gov/employer-resource/

EMPLOYER RESOURCE CENTER

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 with our employer information form. All other forms are located on our Employer Forms page.

Update Employer Information

Employer Services Phone: **888-898-1743**

Closing Remarks

Vangeria Harvey

Acting Director, Alameda


Thank You

Goodbye