Income Withholding Order (IWO)
And
National Medical Support Notice (NMSN)
Packet Review

VENTURA COUNTY DEPARTMENT OF CHILD SUPPORT SERVICES

County of Ventura
Department of Child Support Services

WELCOME

Michael Marcelo

Senior Child Support Attorney

VENTURA COUNTY DEPT. OF CHILD SUPPORT SERVICES
(VCDCSS)
5171 VERDUGO WAY
CAMARILLO CA 93012

9/11/2019

LOCAL MECHANIC SHOP
1234 SKYLINE DR
CAMARILLO, CA 93012

Re: DOE, JOHN

SSN: XXX-XX-XXXX
DOB: 05/03/1984
CSE Case Number:
20000000000000
Participant Number:
300000000000000

Attention Payroll/Benefits Department:

Subject: Income Withholding for Support (IWO) OMB 0970-0154 and National Medical Support Notice (NMSN) OMB 0970-0222 package

This package requires your immediate attention.

Legal Requirements

- The IWO requires you as the employer to deduct a portion of the employee's earnings as defined by Family Code (FC) section 5206 and forward this sum for payment. You must deduct earnings for support up to the maximum amount authorized by law for situations in which the earnings subject to withholding are insufficient to satisfy all support obligations. Instructions for handling deductions are included as part of the IWO. You may deduct a fee of $1.50 from the employee's earnings for each payment. If the enclosed is an amended IWO, you will only receive documents for the case(s) which impacts your employee.
- FC section 17512 also requires employers to report all earnings as defined by FC 5206, including wages, salary, bonus, commission, benefits and any other payments or credits due or becoming due regardless of source.
- Report any bonus or other lump sum payments prior to payout by contacting the Department of Child Support Services (DCSS) at (916) 464-6640 or via email at ***lumpsumresponseteam@dcss.ca.gov***. To report bonus payments through the federal Office of Child Support Enforcement (OCSE) employers may register at ***www.acf.hhs.gov/programs/css/employers/bonus-lump-sum-payments*** or through OCSE via email at ***ACFEmployerServices@acf.hhs.gov***.
- The NMSN requires you to enroll the child(ren) listed in the notice into a group health insurance plan available through employment with your company even if the employee refuses to cooperate. This includes deducting the appropriate cost for the health insurance premium from the earnings of your employee. The cost to enroll the child(ren) into a group health insurance plan (child only portion) should not exceed 5% of the employee's gross (before taxes and deductions) earnings.
- The IWO and NMSN take effect immediately and will remain in effect until further notice. As an employer, you are required by law to comply with these orders and notices, otherwise you may be subject to sanctions or penalties including, but not limited to, those available under FC sections 5241, 3768 and California Code of Civil Procedure section 1218.

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

Forms

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

- Employee copy of each enclosed IWO (OMB 0970-0154) - If you wish to receive the IWO form electronically in the future, visit DCSS at ***www.childsup.ca.gov/Employer/ElectronicIncomeWithholdingOrders(e-iwo).aspx***.
- Request for Hearing Regarding Earnings Assignment (FL-450)
- A copy of each NMSN Part A (OMB 0970-0222) - The information on the Custodial Parent and Child(ren) contained on this page is confidential and should not be shared or disclosed to the employee.
- Request and Notice of Hearing Regarding Health Insurance Assignment (FL-478)
- Information Sheet and Instructions for Request and Notice of Hearing Regarding Health Insurance Assignment (FL-478-INFO)
- Statement of Obligor's Rights and Procedures Regarding a National Medical Support Notice (NMSN) or Health Insurance Assignment Order (DCSS 0361)

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

- Termination of Benefits/Employment Notice (DCSS 0114) - Complete and return this form to the Local Child Support Agency (LCSA) if the employee leaves your employment or has a lapse in health coverage.
- Health Insurance Information (DCSS 0054) - Complete and return this form to the LCSA when health insurance is provided or available through employment with your company.
- Request and Notice of Hearing Regarding Health Insurance Assignment (FL-478)
- Information Sheet and Instructions for Request and Notice of Hearing Regarding Health Insurance Assignment (FL-478-INFO)
- Employee Status Report (DCSS 0522) - Please complete and return this form to the LCSA.

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

Sincerely,

GERARDO GARIN
Child Support Representative

Enclosures

INCOME WITHHOLDING FOR SUPPORT

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

Date: 09/11/2019

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

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

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

Remittance ID (include w/payment) 200000000000000
Order ID DXXXXXX
Case ID 200000000000000

LOCAL MECHANIC SHOP
Employer/Income Withholder's Name

1234 SKYLINE DR
Employer/Income Withholder's Address

CAMARILLO, CA 93012

Employer/Income Withholder's FEIN 123456789

RE: DOE, JOHN
Employee/Obligor's Name (Last, First, Middle)

XXX-XX-XXXX
Employee/Obligor's Social Security Number

05/03/1984
Employee/Obligor's Date of Birth

DOE, JANE
Custodial Party/Obligee's Name (Last, First, Middle)

Child(ren)'s Name(s) (Last, First, Middle)	Child(ren)'s Birth Date(s)
DOE, JOHN JR	07/29/2006

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

$ 21.00 Per MONTH current child support
$ 0.00 Per MONTH past-due child support - **Arrears greater than 12 weeks?** ☐ Yes ☐ No
$ 0.00 Per MONTH current cash medical support
$ 0.00 Per MONTH past-due cash medical support
$ 0.00 Per MONTH current spousal support
$ 0.00 Per MONTH past-due spousal support
$ 0.00 Per MONTH other (must specify) _____.

for a **Total Amount to Withhold** of $ 21.00 per MONTH.

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

$ 4.84 per weekly pay period
$ 10.50 per semimonthly pay period (twice a month)
$ 9.69 per biweekly pay period (every two weeks)
$ 21.00 per monthly pay period
$ _____ **Lump Sum Payment:** Do not stop any existing IWO unless you receive a termination order.

Document Tracking ID _____

Employer's Name: LOCAL MECHANIC SHOP
Employer FEIN: 123456789
Employee/Obligor's Name DOE, JOHN
SSN: XXX-XX-XXXX
Case Identifier: 200000000000000
Order Identifier: DXXXXXX

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 9/11/19. Send payment within 7 business days of the pay date. If you cannot withhold the full amount of support for any or all orders for this employee/obligor, withhold 50 % of disposable income for all orders. If the obligor is a non-employee, obtain withholding limits from Supplemental Information. If the employee/obligor's principal place of employment is not CALIFORNIA (State/Tribe), obtain withholding limitations, time requirements, and any allowable employer fees from the jurisdiction of the employee/obligor's principal place of employment. State-specific withholding limit information is available at www.acf.hhs.gov/css/resource/state-income-withholding-contacts-and-program-requirements. For tribe-specific contacts, payment addresses, and withholding limitations, please contact the tribe at www.acf.hhs.gov/sites/default/files/programs/css/tribal_agency_contacts_printable_pdf.pdf or https://www.bia.gov/tribalmap/DataDotGovSamples/tid_map.html.

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

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

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

☐ **Return to Sender (Completed by Employer/Income Withholder).** Payment must be directed to an SDU in accordance with sections 466(b)(5) and (6) of the Social Security Act or Tribal Payee (see Payments to SDU below). If payment is not directed to an SDU/Tribal Payee or this IWO is not regular on its face, you *must* check this box and return the IWO to the sender.

If Required by State or Tribal Law:
Signature of Judge/Issuing Official: _____
Print Name of Judge/Issuing Official: GERARDO GARIN
Title of Judge/Issuing Official: Child Support Representative
Date of Signature: _____

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

ADDITIONAL INFORMATION FOR EMPLOYERS/INCOME WITHHOLDERS

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

Employers/income withholders may use OCSE's Child Support Portal (https://ocsp.acf.hhs.gov/csp/) to provide information about employees who are eligible to receive a lump sum payment, have terminated employment, and to provide contacts, addresses, and other information about their company.

Priority: Withholding for support has priority over any other legal process under State law against the same income (section 466(b)(7) of the Social Security Act). If a federal tax levy is in effect, please notify the sender.

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

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

Employer's Name: LOCAL MECHANIC SHOP Employer FEIN: 123456789
Employee/Obligor's Name: DOE, JOHN SSN: XXX-XX-XXXX
Case Identifier: 200000000000000 Order Identifier: DXXXXXX

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

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

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

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

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

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

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

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

Supplemental Information:

Employer's Name: LOCAL MECHANIC SHOP Employer FEIN: 123456789
Employee/Obligor's Name: DOE, JOHN SSN: XXX-XX-XXXX
Case Identifier: 200000000000000 Order Identifier: DXXXXXX

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

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

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

Please provide the following information for the employee/obligor:

Termination date: _____ Last known phone number: _____

Last known address: _____

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

New employer's name: _____

New employer's address: _____

CONTACT INFORMATION:

To Employer/Income Withholder: If you have questions, contact California Department of Child Support Services (issuer name) by telephone: (866) 901-3212, by fax: _____, by email or website: http://www.childsup-connect.ca.gov

Send termination/income status notice and other correspondence to: VENTURA
5171 VERDUGO WAY, CAMARILLO CA 93012 (issuer address).

To Employee/Obligor: If the employee/obligor has questions, contact GERARDO GARIN (issuer name) by telephone: (866) 901-3212, by fax: (805) 437-8308, by email or website: _____

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

Encryption Requirements:
When communicating this form through electronic transmission, precautions must be taken to ensure the security of the data. Child support agencies are encouraged to use the electronic applications provided by the federal Office of Child Support Enforcement. Other electronic means, such as encrypted attachments to emails, may be used if the encryption method is compliant with Federal Information Processing Standard (FIPS) Publication 140-2 (FIPS PUB 140-2).

The Paperwork Reduction Act of 1995
This information collection and associated responses are conducted in accordance with 45 CFR 303.100 of the Child Support Enforcement Program. This form is designed to provide uniformity and standardization. Public reporting for this collection of information is estimated to average two to five minutes per response. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address):	FOR COURT USE ONLY
20000000000000 TELEPHONE NO.: FAX NO. (Optional): E-MAIL ADDRESS (Optional): ATTORNEY FOR (Name):	
SUPERIOR COURT OF CALIFORNIA, COUNTY OF VENTURA STREET ADDRESS: 800 S. VICTORIA AVE MAILING ADDRESS: 800 S. VICTORIA AVE CITY AND ZIP CODE: VENTURA 93009 BRANCH NAME: VENTURA COUNTY SUPERIOR COURT	
PETITIONER/PLAINTIFF: JANE DOE RESPONDENT/DEFENDANT: JOHN DOE OTHER PARENT:	
REQUEST FOR HEARING REGARDING EARNINGS ASSIGNMENT	CASE NUMBER: DXXXXXX

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

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

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

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

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

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

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

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

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

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

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

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

PETITIONER/PLAINTIFF: JANE DOE RESPONDENT/DEFENDANT: JOHN DOE OTHER PARENT:	CASE NUMBER: DXXXXXX

3. ☐ I request that the earnings assignment be modified because

   a. ☐ the total amount of arrearages claimed as owing is incorrect. *(Check one or more of the following reasons.)*

      (1) ☐ I did not receive credit for all of the payments I have made. *(Check (a), (b), or both.)*

         (a) ☐ I have attached my statement of the payment history, which includes a monthly breakdown of amounts ordered and amounts paid.

         (b) ☐ I made the following payments that were not credited *(for each payment, specify the date, the amount, and the name of the person or agency paid)*:

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

      (3) ☐ Other *(specify)*:

   b. ☐ the monthly payment specified in the earnings assignment is more than half of my total net income each month from all sources.

   c. ☐ the monthly arrearage payment stated in the earnings assignment creates an undue hardship because *(describe the hardship and state the amount you are able to pay on your arrearage)*:

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

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

Date:

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

CLERK'S CERTIFICATE OF MAILING

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

Date: Clerk, by _____, Deputy

INFORMATION SHEET AND INSTRUCTIONS FOR REQUEST FOR HEARING REGARDING EARNINGS ASSIGNMENT

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

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

(TYPE OR PRINT IN INK)

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

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

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

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

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

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

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

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

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

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

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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: VENTURA DCSS Issuing Agency Address: 5171 VERDUGO WAY CAMARILLO CA 93012 Notice Date: 9/11/2019 CSE Agency Case Identifier: 20000000000000 Telephone Number: (866) 901-3212 FAX Number: (805) 437-8308	Court or Administrative Authority: SUPERIOR COURT OF CALIFORNIA, COUNTY OF VENTURA Order Date: 03/02/2011 Order Identifier: DXXXXXX Document Tracking Identifier: Employer web site: See NMSN Instructions: http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form

RE:

123456789 Employer/Withholder's Federal EIN Number	DOE, JOHN Employee's Name (Last, First, MI)
LOCAL MECHANIC SHOP Employer/Withholder's Name	XXX-XX-XXXX Employee's Social Security Number
1234 SKYLINE DR CAMARILLO, CA 93012 Employer/Withholder's Address	Employee's Mailing Address
Custodial Parent's Name (Last, First, MI)	VENTURA COUNTY DEPT. OF CHILD SUPPORT SERVICES (VCDCSS) Substituted Official/Agency Name
Custodial Parent's Mailing Address	5171 VERDUGO WAY CAMARILLO CA 93012 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
DOE, JOHN JR		07/29/2006	XXX-XX-1111				

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

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

LIMITATIONS ON WITHHOLDING

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

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

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

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

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

PRIORITY OF WITHHOLDING

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

EMPLOYER RESPONSE

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

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

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

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

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

Date of termination: _____

Last known telephone number: _____

Last known address: _____

New employer (if known): _____

New employer telephone number: _____

New employer address: _____

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

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

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

CONTACT FOR QUESTIONS

Plan Administrator Name: _____
Contact Person: _____

FAX Number: _____
Telephone Number: _____

Employer Name: LOCAL MECHANIC SHOP
Employer Representative Name/Title: _____

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

Employee Name: JOHN DOE
30000000000000

Date: _____

INSTRUCTIONS TO EMPLOYER

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

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

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

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

EMPLOYER RESPONSIBILITIES

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

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

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

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

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

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

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

DURATION OF WITHHOLDING

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

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

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

POSSIBLE SANCTIONS

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

NOTICE OF TERMINATION OF EMPLOYMENT

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

EMPLOYEE LIABILITY FOR CONTRIBUTION TO PLAN

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

CONTACT FOR QUESTIONS

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

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

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

Issuing Agency: VENTURA DCSS Issuing Agency Address: 5171 VERDUGO WAY CAMARILLO CA 93012 Notice Date: 09/11/2019 CSE Agency Case Identifier: 20000000000000 Telephone Number: (866) 901-3212 FAX Number: (805) 437-8308	Court or Administrative Authority: SUPERIOR COURT OF CALIFORNIA, COUNTY OF VENTURA Order Date: 03/02/2011 Order Identifier: DXXXXXX Document Tracking Identifier: Employer web site: See NMSN Instructions: http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form

123456789
Employer/Withholder's Federal EIN Number

LOCAL MECHANIC SHOP
Employer/Withholder's Name

1234 SKYLINE DR
CAMARILLO, CA 93012
Employer/Withholder's Address

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

_____
Custodial Parent's Mailing Address

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

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

RE: DOE, JOHN
Employee's Name (Last, First, MI)

XXX-XX-XXXX
Employee's Social Security Number

PO BOX 666
LOST HILLS CA 93249-0666
Employee's Mailing Address

VENTURA COUNTY DEPT. OF CHILD SUPPORT SERVICES (VCDCSS)
Substituted Official/Agency Name

5171 VERDUGO WAY
CAMARILLO CA 93012
Substituted Official/Agency Address
(Required if Custodial Parent's mailing address is left blank)

_____
Mailing Address of a Representative of the Child(ren)

Child(ren)'s Name(s)	Gender	DOB	SSN	Child(ren)'s Name(s)	Gender	DOB	SSN
DOE, JOHN JR		07/29/2006	111-11-1111				

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

THE PAPERWORK REDUCTION ACT OF 1995 (P.L. 104-13) public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.
OMB control number: 1210-0113 Expiration Date: 08/31/2019.

PLAN ADMINISTRATOR RESPONSE

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

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

This Notice was received by the plan administrator on _____.

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

2. The participant (employee) and alternate recipient(s) (child(ren)) are to be enrolled in the following family coverage.
   a. The child(ren) is/are currently enrolled in the plan as a dependent of the participant.
   b. There is only one type of coverage provided under the plan. The child(ren) is/are included as dependents of the participant under the plan.
   c. The participant is enrolled in an option that is providing dependent coverage and the child(ren) will be enrolled in the same option.
   d. The participant is enrolled in an option that permits dependent coverage that has not been elected; dependent coverage will be provided.

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

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

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

5. This Notice does not constitute a "qualified medical child support order" because:
   The name of the child(ren) or participant is unavailable.
   The mailing address of the child(ren) (or a substituted official) or participant is unavailable.
   The following child(ren) is/are at or above the age at which dependents are no longer eligible for coverage under the plan _____ (insert name(s) of child(ren)).

Plan Administrator or Representative:

Name: _____ Telephone Number: _____

Title: _____ Date: _____

Address: _____

LOCAL MECHANIC SHOP JOHN DOE 30000000000000

INSTRUCTIONS TO PLAN ADMINISTRATOR

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

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

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

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

(a) if you checked Response 2:

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

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

(b) if you checked Response 3:

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

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

(c) if the participant is subject to a waiting period that expires more than 90 days from the date of receipt of this Notice, or has not completed a waiting period whose duration is determined by a measure other than the passage of time (for example, the completion of a certain number of hours worked), complete Response 4 on the Plan Administrator Response and return to the employer and the Issuing Agency, and notify the participant and the custodial parent; and upon satisfaction of the period or requirement, complete enrollment under Response 2 or 3, and

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

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

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

UNLAWFUL REFUSAL TO ENROLL.

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

PAYMENT OF CLAIMS

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

PERIOD OF COVERAGE

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

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

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

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

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

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

CONTACT FOR QUESTIONS

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

Paperwork Reduction Act Notice

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

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

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

DCSS 0361 (09/02/05)

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

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

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

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

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

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

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

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What else do you need to know?

IWO – Notification of Employment and Termination

- Return the Notification of Employment Termination or Income Status (found within the IWO) or call us at 1-866-901-3212.
- Provide the termination date and employee's last known address.
- If you know the name and/or address of the employee's new employer, please provide this information.

Employer's Name: LOCAL MECHANIC SHOP Employer FEIN: 123456789
Employee/Obligor's Name: DOE, JOHN SSN: XXX-XX-XXXX
Case Identifier: 20000000000000 Order Identifier: DXXXXXX

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

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

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

Please provide the following information for the employee/obligor:

Termination date: _____ Last known phone number: _____

Last known address: _____

_____

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

New employer's name: _____

New employer's address: _____

_____

CONTACT INFORMATION:

To Employer/Income Withholder: If you have questions, contact California Department of Child Support Services (issuer name) by telephone: (866) 901-3212, by fax: _____, by email or website: http://www.childsup-connect.ca.gov

Send termination/income status notice and other correspondence to: VENTURA
5171 VERDUGO WAY, CAMARILLO CA 93012 (issuer address).

NMSN Termination of Benefits/Employment Notice

- If the employee leaves your employment or has a lapse in health insurance coverage for the dependents, complete and return this form within 10 business days.
- Provide the termination date and employee's last known address.
- If you know the name and/or address of the employee's new employer, please provide this information.
- Link to form:

  https://childsupport.ca.gov/wp-content/uploads/sites/252/Employers/Termination-of-Benefits.pdf

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF CHILD SUPPORT SERVICES

TERMINATION OF BENEFITS / EMPLOYMENT NOTICE

DCSS 0114 (08/21/2018)

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?

Health Insurance Information

- Complete and return this form when:
  - The children listed on the NMSN are already enrolled in the employee's health insurance through employment with your company
  - The children listed on the NMSN are added to the employee's health insurance
- Link to form:

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

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

Updating Employer Demographics

- https://childsupport.ca.gov/employer-update-contact-information-form/

Employer Update Contact Information Form

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

Employer Forms

To request versions accessible to persons with visual disabilities,

Dear Employers:

Thank you for visiting our website and for your interest in updating your company information. Maintaining accurate employer information with the California Department of Child Support Services benefits employers by ensuring notices are sent to the proper location and preventing issuance of duplicate notices. The information you provide will be used to issue Income Withholding Orders, Medical Support Notices and Employment Verifications to the appropriate addresses and individuals. This information will not be shared with any outside agency. Thank you for your participation and for keeping us informed.

Update your information using the Employer Information Update Form.

Sincerely,
Employer Services

* Required field

EMPLOYER LEGAL/REGISTERED INFORMATION

CSE Employer Number
Note: If you received an Employer Information Request form from DCSS, the CSE Employer Number is located on the top right of the form.

* 9 Digit Federal Identification Number (FEIN) OR ☐No FEIN, Employer reports with SSN
(Do not include the dash) (Do not provide SSN)

* Employer Legal Name (Corp/Inc/LLC) OR ☐Sole Proprietor (Owner's Name)

Employer "Doing Business As" Name

PAYROLL/GARNISHMENT INFORMATION

Receive Income Withholding Orders Electronically (e-IWO)

Federal law requires that employers have the option of receiving IWOs electronically. California uses the federal e-IWO Process to save you time and money!