

### Child Support Information Transmittal

<b>TO:</b>	<input type="checkbox"/> PA	<input type="checkbox"/> Foster Care	<input type="checkbox"/> DV Liaison	<input type="checkbox"/> Child Support	<input type="checkbox"/> Other _____
	<input type="checkbox"/> MA	<input type="checkbox"/> Day Care	<input type="checkbox"/> Fraud	<input type="checkbox"/> Employment Unit	
<b>FROM:</b>	<input type="checkbox"/> PA	<input type="checkbox"/> Foster Care	<input type="checkbox"/> DV Liaison	<input type="checkbox"/> Child Support	<input type="checkbox"/> Other _____
	<input type="checkbox"/> MA	<input type="checkbox"/> Day Care	<input type="checkbox"/> Fraud	<input type="checkbox"/> Employment Unit	
CUSTODIAL PARENT NAME (Last, First, MI)					
NONCUSTODIAL PARENT NAME (Last, First, MI)					
NY CASE IDENTIFIER #	TA/MA CASE #	DATE			

#### SECTION I: Child Support Information (Completed by Child Support)

**Cooperation** – Applicant/recipient cooperated with Child Support on \_\_\_\_\_

**Exception to Cooperation** – Applicant/recipient claims

Domestic Violence

Good Cause

Details: \_\_\_\_\_  
\_\_\_\_\_

**Non-Cooperation** – On \_\_\_\_\_, applicant/recipient failed or refused to:

Appear for Child Support interview

Provide required information or attest to lack of information

Provide to Child Support the requested documentation: \_\_\_\_\_

Appear and participate in court or other hearing

Submit self and child to paternity testing

Pay to the Support Collection Unit assigned support money received directly

Details: \_\_\_\_\_  
\_\_\_\_\_

**Household Change/Possible Fraud**

Child(ren) not in the household

Noncustodial Parent in the household

Applicant/recipient is receiving unreported support money directly

Details, including dates: \_\_\_\_\_  
\_\_\_\_\_

LDSS-2859 (Rev. 02/10)

NY Case Identifier: \_\_\_\_\_

Child Support Case Update

Putative father:  acknowledged  adjudicated  excluded as the father of \_\_\_\_\_  
by \_\_\_\_\_ Court on \_\_\_\_\_. Please take the following action: \_\_\_\_\_

Support order  Original  Modified Effective Date: \_\_\_\_\_ Docket #: \_\_\_\_\_

TYPE OF SUPPORT	AMOUNT	PER
<input type="checkbox"/> Current		
<input type="checkbox"/> Arrears		
<input type="checkbox"/> Cash Medical Support Obligations (CMSO)		
<input type="checkbox"/> MA Managed Care		
<input type="checkbox"/> MA Fee-for-Service (Maximum Annual CMSO)		
<input type="checkbox"/> Court ordered payment of MA Fee-for-Service claim		
<b>TOTAL</b>		

Third Party Health Insurance Coverage:

Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_ Coverage:  Medical  Dental  Optical  Prescription

Persons Covered: \_\_\_\_\_

Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_ Coverage:  Medical  Dental  Optical  Prescription

Persons Covered: \_\_\_\_\_

Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_ Coverage:  Medical  Dental  Optical  Prescription

Persons Covered: \_\_\_\_\_

Redirect support payments to  DSS  Family effective \_\_\_\_\_

Request for Medicaid Transmittal Form

TA case  FC case  MA-only case

Child(ren)'s names: \_\_\_\_\_

Comments: \_\_\_\_\_

Comments on Pending Good Cause/Domestic Violence Determination: \_\_\_\_\_

Other Information: \_\_\_\_\_

**SECTION II: Case Information** (Completed by Referring Program)

Applicant/recipient reported new/changed information: \_\_\_\_\_

Good Cause claim:  granted  denied \_\_\_\_\_

Domestic Violence Waiver:  full  partial  denied \_\_\_\_\_

Please provide the following information about the child support case: \_\_\_\_\_

Medicaid Transmittal Form attached

Other: \_\_\_\_\_

**SECTION III: Signature** (Completed by Child Support or Referring Program)

CASE WORKER	TELEPHONE NUMBER	DATE
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