Attachment 3

LDSS-2859 (Rev. 02/10)

Child Support Information Transmittal

TO:	☐ PA	☐ Foster Care	☐ DV Liaison	☐ Child Support	☐ Other __________
	☐ MA	☐ Day Care	☐ Fraud	☐ Employment Unit	
FROM:	☐ PA	☐ Foster Care	☐ DV Liaison	☐ Child Support	☐ Other __________
	☐ MA	☐ Day Care	☐ Fraud	☐ 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: ____

____

____

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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
☐ Current		
☐ Arrears		
☐ Cash Medical Support Obligations (CMSO)		
☐ MA Managed Care		
☐ MA Fee-for-Service (Maximum Annual CMSO)		
☐ Court ordered payment of MA Fee-for-Service claim		
TOTAL		

☐ 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