



Cuyahoga County

Office of Child Support Services

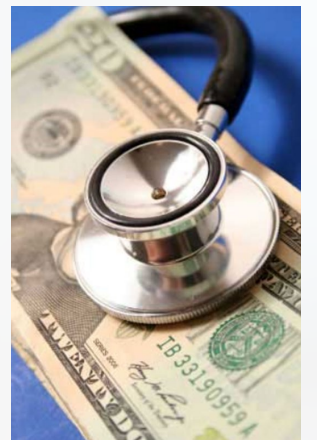
2025 Employer Workshop

Medical Support



Medical Support – The Basics

- **All child support orders include an order for medical support**
- **Monetary cash medical support**
 - For support orders prior to 3/28/2019, is charged when ordered health coverage is not being provided
 - For support orders on/after 3/28/2019, is not connected to health insurance and is always charged
 - Is included in income withholding order
 - New income withholding order is issued when cash medical support starts or stops
- **Private health insurance coverage**
 - Either parent may be ordered to provide medical coverage
 - Employers may receive either of two forms regarding insurance coverage



JFS 07625 Health Insurance Disclosure Form



Issued for parents who MAY be required to provide health insurance coverage for child

If employee is already carrying coverage, include information about the policy, costs, and children covered

If employee is not currently carrying coverage, indicate so and provide cost information for OCSS to make determination on whether coverage can be ordered

May be received along with request to verify employment/wages

JFS 07625 Health Insurance Disclosure Form

<County Name> County CSEA
<CSEA Address 1>
<CSEA Address 2>
<CSEA City, State, ZIP>

HEALTH INSURANCE DISCLOSURE INFORMATION
EMPLOYER USE ONLY

Case #: <SETS #>

Do you currently employ <Employee Name>? Yes No

If "no", please list previous employer(s):

< Previous Employer >	< Previous Employer >
< Previous Employer >	< Previous Employer >
< Previous Employer >	< Previous Employer >
< Previous Employer >	< Previous Employer >

Current Mailing Address or Last Known Address
<Mailing Address 1> <Mailing Address 1>
<Mailing Address 2> <Mailing Address 2>
<City, State, ZIP> <City, State, ZIP>

Name of Insurance Provider: <Name of Insurance Provider>
Address: <Mailing Address 1>
<Mailing Address 2>
<City, State, ZIP>

Type of Insurance Coverage: Vision Dental Major Medical Prescription Drug Mental Health
 Other <Other - describe>

Insurance Effective Date: <Insurance Effective Date>
Insurance Policy Number: <Insurance Policy Number> Group Number: <Group Number>

If insurance is not being provided by employee is it available? Yes No
Cost for Individual coverage? \$ <Cost for Individual Coverage>
Cost for Family coverage? \$ <Cost for Family Coverage>
Cost for Individual Plus One coverage \$ <Cost for Individual Plus One Coverage>

Are the following child(ren) currently covered on the employee's policy?

	Yes	No		Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Contact person with your Company:
Name: <Contact Person Name> Phone: <Phone Number>
Title: <Title>

Currently employed by you?

Previous employers (if known)

Current/last known employee mailing address

Name/address of insurance provider

Coverage info (if insurance already provided)

Coverage availability/cost info
(Are costs weekly/monthly/annual?)

Which children are/are not covered?

Your contact info



National Medical Support Notice (OMB 00970-0222)



Part A – 5 pages (for employer)

**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.

National Medical Support Order/Notice (NMSN) **Termination Order/Notice (Optional)**

Issuing Agency: <CSEA Name>	Court or Administrative Authority: <CSEA Name>
Issuing Agency Address: <CSEA Address>	Order Date: <Date of Support Order>
Notice Date: <Print Date>	Order Identifier: <Order No.>
CSE Agency Case Identifier: <Case No.>	Document Tracking Identifier:
Telephone Number: <CSEA Local Phone No.>	Employer web site:
FAX Number: <CSEA Fax No.>	See NMSN Instructions: http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form

RE: <Employee's Name>

<Employer/Withholder's Federal EIN Number>	Employee's Name (Last, First, MI)
<Employer/Withholder's Name>	<Employee's Social Security Number>
<Employer/Withholder's Address 1>	Employee's Social Security Number
<Employer/Withholder's Address 2>	<Employee's Mailing Address 1>
<Employer/Withholder's City, State ZIP>	<Employee's Mailing Address 2>
<Employer/Withholder's Address	<Employee's City, State ZIP>
<Custodial Parent's Name>	Employee's Mailing Address
<Custodial Parent's Name (Last, First, MI)>	Substituted Official/Agency Name
<Custodial Parent's Mailing Address 1>	
<Custodial Parent's Mailing Address 2>	
<Custodial Parent's City, State ZIP>	
<Custodial Parent's Mailing Address	Substituted Official/Agency Address (Required if Custodial Parent's mailing address is left blank)

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

Child(ren)'s Name(s)	Gender	DOB	SSN	Child(ren)'s Name(s)	Gender	DOB	SSN
<Child's Name>	<M/F>	<dob>	<ssn>	<Child's Name>	<M/F>	<dob>	<ssn>
<Child's Name>	<M/F>	<dob>	<ssn>	<Child's Name>	<M/F>	<dob>	<ssn>
<Child's Name>	<M/F>	<dob>	<ssn>	<Child's Name>	<M/F>	<dob>	<ssn>

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

THE PAPERWORK REDUCTION ACT OF 1995 (P.L. 104-13) Public reporting burden for this collection of information is estimated to average 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: 10/31/2022.

NMSN - Part A Page 1 of 5

Part B – 7 pages (for health plan administrator)

**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: <County CSEA Name>	Court or Administrative Authority: <County Name>
Issuing Agency Address: <CSEA Address>	Order Date: <Date of Support Order>
Notice Date: <Print Date>	Order Identifier: <Court Order #>
CSE Agency Case Identifier: <case no.>	Document Tracking Identifier:
Telephone Number: <CSEA Local Phone No.>	Employer web site:
FAX Number: <CSEA Fax No.>	See NMSN Instructions: http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form

RE: <Employee's Name>

<Employer/Withholder's Federal EIN Number>	Employee's Name (Last, First, MI)						
<Employer/Withholder's Name>	<Employee's Social Security Number>						
<Employer/Withholder's Address 1>	Employee's Social Security Number						
<Employer/Withholder's Address 2>	<Employee's Mailing Address 1>						
<Employer/Withholder's City, State ZIP>	<Employee's Mailing Address 2>						
<Employer/Withholder's Address	<Employee's Mailing City, State ZIP>						
<Custodial Parent's Name>	Employee's Mailing Address						
<Custodial Parent's Name (Last, First, MI)>	Substituted Official/Agency Name						
<Custodial Parent's Mailing Address							
<Custodial Parent's Mailing Address							
<Custodial Parent's Mailing Address							
<Child(ren)'s Mailing Address 1 (if different)>	Substituted Official/Agency Address (Required if Custodial Parent's mailing address is left blank)						
<Child(ren)'s Mailing Address 2 (if different)>							
<Child(ren)'s Mailing City, State, ZIP (if different)>							
Child(ren)'s Mailing Address (if different from Custodial Parent's)	<Mailing Address of Representative 1>						
<Name & Phone # of Representative>	<Mailing Address of Representative 2>						
Name and Telephone of a Representative of the Child(ren)	<Mailing City, State ZIP of Representative>						
	Mailing Address of a Representative of the Child(ren)						
Child(ren)'s Name	Gender	DOB	SSN	Child(ren)'s Name(s)	Gender	DOB	SSN
<child's Name>	<M/F>	<dob>	<ssn>	<child's Name>	<M/F>	<dob>	<ssn>
<child's Name>	<M/F>	<dob>	<ssn>	<child's Name>	<M/F>	<dob>	<ssn>
<child's Name>	<M/F>	<dob>	<ssn>	<child's Name>	<M/F>	<dob>	<ssn>

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

THE PAPERWORK REDUCTION ACT OF 1995 (P.L. 104-13) No persons are required to respond to a collection of information unless it displays a valid OMB control number. The time required to complete this information collection is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete the review of the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form please write to: Joseph Piacentini, Office of Policy and Research, Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue NW, Room-N5718, Washington, DC 20210 or email sbsa.opr@dol.gov and reference the OMB Control Number. OMB control number: 1210-0113 Expiration Date: 10/31/2022.

NMSN - Part B Page 1 of 5

National Medical Support Notice (OMB 00970-0222)



Part A includes:

- Identifying information for employee and case (page 1)
- Page 2
 - Information on withholding limitations
 - Priority of withholding
 - Termination information (if applicable)
- Employer response (page 3)
- Instructions to employer (pages 4 and 5)

Possible employer responses (part A, Page 3)

1. Employee was never employed by you
2. Employer does not provide health care coverage
3. Employee is not eligible for health care
4. Employee is no longer employed by you
5. Deduction exceeds withholding limits
6. Other
7. Employee is subject to waiting period
8. Employee on unpaid leave of absence.
9. Date Part B was forwarded to Health Plan Administrator

Return within 20 business days

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).

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 3rd party, other reason for no coverage): _____

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: _____

COMPLETED BY:

Employer Company Name _____	Plan Administrator Company / Union Name _____
Contact Name: _____	Contact Name: _____
Title: _____	Title: _____
Email: _____	Email: _____
Telephone: _____	Telephone: _____
FAX: _____	FAX: _____
FEIN: _____	FEIN: _____

NMSN – Part A RE: <employee name>, <case identifier> Page 3 of 5

National Medical Support Notice



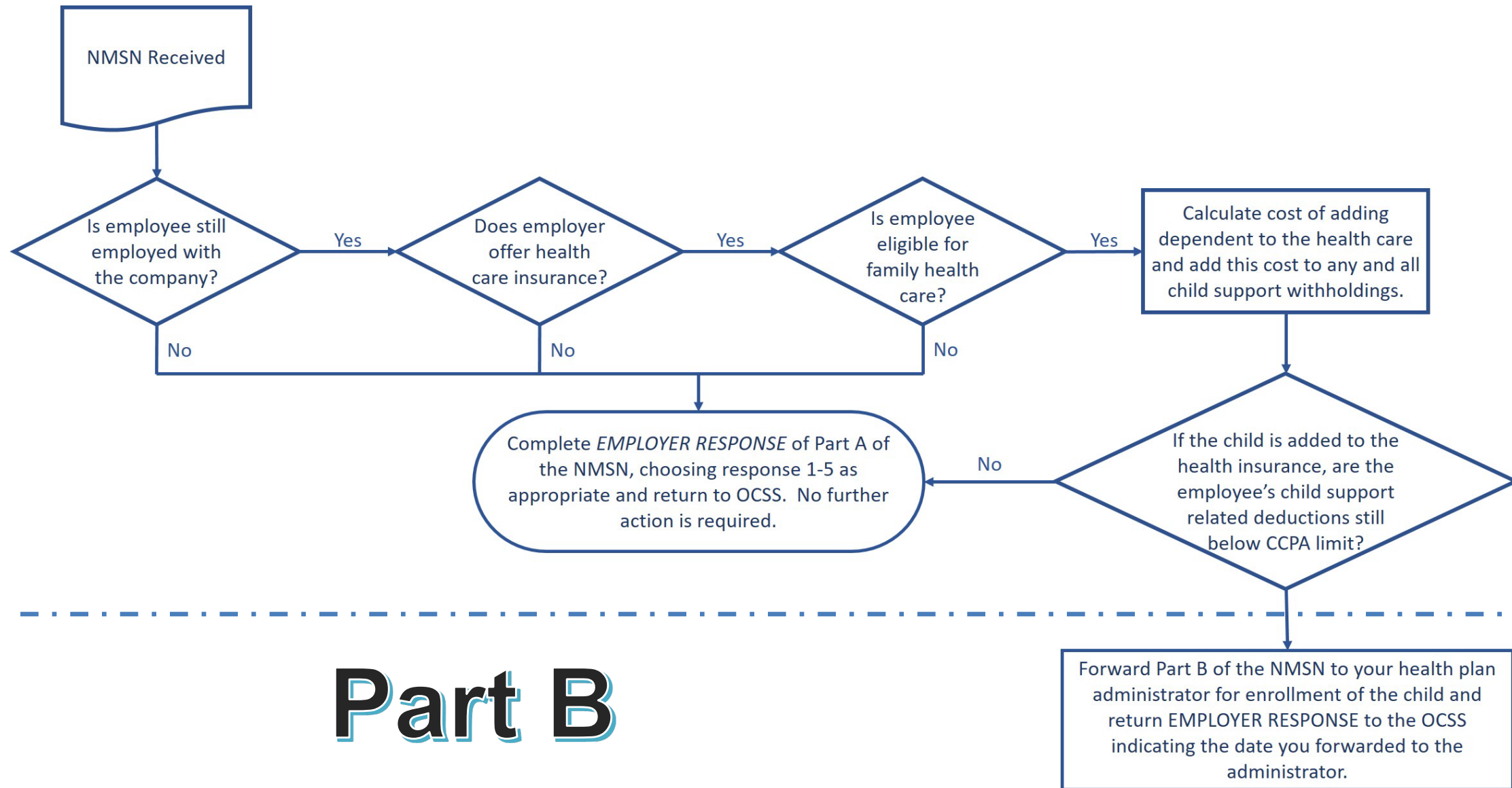
Part B includes:

- Identifying information for employee and case (page 1)
- Health plan administrator response (page 2)
- Instructions to plan administrator (pages 3-5)
- Addendum to list coverage info (pages 6-7)

Action Steps

- Enroll child after any required waiting period (must be less than 90 days)
- Provide necessary coverage information to the custodial parent
- Return Administrator response within 40 days to child support agency that issued NMSN

National Medical Support Notice Workflow



Part B



Employees with Waiting Periods

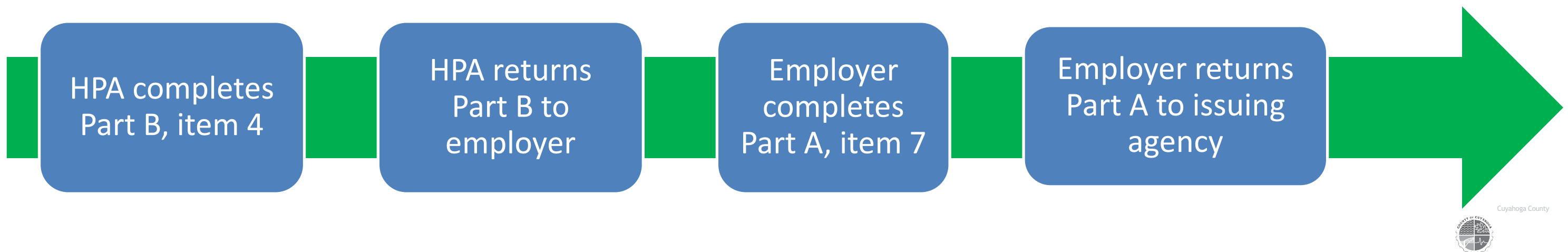


If waiting period ends less than 90 days from date of Notice:

- Health Plan Administrator completes Part B, item 2 in response
- Administrator indicates date coverage will become effective

If waiting periods ends more than 90 days from date of Notice OR is based on other criteria:

- Administrator indicates this on Part B, item 4 and returns it to employer
- Employer completes Part A, item 7 and returns it to child support agency that issued NMSN



Other good-to-know info



Ohio HB366 (effective in 2019) means that more custodial parents may be ordered to provide health care coverage

If health coverage costs exceed CCPA limits, employee may voluntarily elect coverage

NMSN may be followed by immediate termination (JFS 04098)

- Federal and state regulations require systemic issuance of NMSN when health care coverage is ordered
- Our system automatically issues NMSN when order is input
- In cases where OCSS or court has determined that costs exceed reasonable cost threshold, JFS 04098 will be issued immediately to terminate NMSN

Test for reasonable cost now uses total out-of-pocket costs vice marginal costs between self-only and family coverage

Employer never determines cost reasonability

Employee has specific administrative hearing rights with OCSS

A few things to remember...



NMSN is a Qualified Medical Child Support Order

- Employers have the obligation to respond and act
- Employees may not override what is ordered in NMSN

Do not wait for open enrollment

- Enroll child immediately after any waiting period expires

Coverage ordered for children should be flagged to prevent open season disenrollment by employee

Provide custodial parent coverage details & necessary documents to use insurance

Do not share confidential info with employee

Contact Information



The OCSS Medical Team can be reached at 216-443-5221

Documents can be returned:

By email: CUYAHOGA_MEDTEAM@jfs.ohio.gov

By fax: 216-443-5757

**By mail: P.O. Box 93318
Cleveland, OH 44101**



Questions???





Cuyahoga County

Office of Child Support Services
1640 Superior Ave.
Cleveland, OH 44114

Phone: (216) 443-5100
Email: CUYCSEA@JFS.OHIO.GOV