

To be put on County DSS letterhead

MEDICAID CASH MEDICAL SUPPORT BILLING STATEMENT TO NON-CUSTODIAL PARENT

Date _____/_____/20____

To:

Child(ren)'s WMS Case #: _____

Child(ren)'s NAME(s) / CIN(s) #:
_____/_____
_____/_____
_____/_____
_____/_____

New York Child Support Case Identifier:

Court Docket/File #: _____

NCP Date of Birth: ____/____/____

NCP SSN: XXX - XX - _____

Dear _____,

As the Noncustodial Parent (NCP) for the child(ren) listed above who receives(ed) Medicaid (MA), the court has ordered you to reimburse MA expenditures that have been incurred by and paid on behalf of the child(ren) who are named in the order of support. The court order of support requires that you pay up to \$_____ for the year of _____, which is your **maximum annual cash medical support obligation (MACMSO)** amount, **OR** the **actual total** amount of MA expenditures incurred by and paid on behalf of the child(ren), **whichever is less**. If there is an additional MACMSO amount stated in the court order that addresses MA expenditures paid on behalf of the child(ren) for time periods **prior** to the current year, this amount will be shown in **Box 3c**. The **total amount** of Cash Medical Support **that you currently owe** to the County DSS for the child(ren) listed above is shown in **Box 4c** on the reverse side of this notice. Payment instructions are listed in **Box 5**. A warning if you fail to pay is shown in **Box 6**. If you need more information or have any questions contact information is shown in **Box 7**.

Actual Incurred / Paid MA Expenditures for the Year _____

1

a) Total MA Expenditures paid on behalf of (child's name) _____	\$
b) Total MA Expenditures paid on behalf of (child's name) _____	\$
c) Total MA Expenditures paid on behalf of (child's name) _____	\$
d) Total MA Expenditures paid on behalf of (child's name) _____	+\$
e) Total MA Expenditures Paid for _____ to _____ for Year of _____ (add a, b, c and d)	=\$ Total

Amount Due from NCP for the Year of _____

2

a) Amount of combined child(ren)'s MA expenditures for year _____ (Total MA expenditures amount from Box 1e above)	\$
b) NCP's MACMSO amount for year _____ (enter the current amount from court order)	\$
c) Enter the Lesser of: Total of MA Expenditures for Year _____ OR the current CMSO amount for year _____ (compare a with b and enter the lesser amount in c)	\$
d) Total Amount NCP has already paid toward MA Expenditures for the child(ren) for year _____ (check accounting records for payments) (subtract d from c)	-\$ ()
e) Remaining Amount Due From NCP for the Year of _____ (Balance)	\$ Remaining Amount Due

Amount Due from NCP from Prior Year(s): As stated in court order. Do not enter amounts previously provided to child support on the OHIP 0030, Medicaid Medical Support Transmittal (MA to CSEU) for enforcement

3	a) Amount Due from NCP from Prior Year(s) of _____ for child(ren) (enter amount only if stated in court order)	\$ _____
	b) Amount NCP has already paid toward Amounts Due from Prior Year(s) (check account records for payments) (subtract b from a)	-\$ (_____)
	c) Remaining Amount Due from NCP for prior year(s) as per court order (balance)	\$ Prior years MACMSO remaining balance due

Total Amount of Cash Medical Support Due for the NCP to Pay to County DSS

4	a) Remaining Amount Due from NCP for Year _____ from Box 2e	\$ _____
	b) Remaining Amount Owed by NCP for Prior Year(s) from Box 3c (enter as per court order)	+\$ _____
	c) TOTAL AMOUNT OF CASH MEDICAL SUPPORT DUE FROM NCP For the Time Periods Indicated in this Billing Statement: (add amounts due for current and prior year(s) from Boxes 2e +3c) resulting in the total amount due payable to _____ County Department of Social Services	=\$ Total \$ due to LDSS

Procedures for Payment Due to County DSS

You must submit your payment for the Total Amount of Cash Medical Support in **Box 4c** due to the County DSS, within thirty (30) calendar days of the date of this notice. If you would like to discuss a different payment plan, please contact us at the telephone number provided below.

- Payments must be made by Money Order or Cashier's Check.
- Make all payments payable to: _____.
- Send payments to the County Department of Social Services address listed on the front of this notice to the attention of _____.

Failure to Pay

Your failure to pay the amount of Cash Medical Support due to the County DSS may result in a referral to the NYS Child Support Enforcement Unit for additional enforcement of the current court order.

County DSS Contact Information

For more information, or if you have any questions, please contact _____ at (_____) XXX - XXXX, or by mail at the County DSS address on the front of this notice.

Agency Certification

I hereby certify that: (1) I am an employee of the _____ County Department of Social Services; (2) the information in this billing statement was taken from the records of the _____ County Department of Social Services; (3) such information is maintained in the regular course of business; (4) it is the regular course of such business to maintain such information; and (5) a memorandum or record of the information was made at the time of the act, transaction, occurrence or event, or within a reasonable time thereafter. I certify that I have been designated and authorized by the Commissioner of _____ County Department Social Services for the purpose of making this certification.

Dated: _____

Phone # () _____

Signature

Print Name

Title