

**Medicaid Medical Support Transmittal**

County Name \_\_\_\_\_ WMS Case Number \_\_\_\_\_ Date \_\_\_\_\_

To \_\_\_\_\_ Unit/Agency \_\_\_\_\_ Telephone # \_\_\_\_\_

From \_\_\_\_\_ Unit/Agency \_\_\_\_\_ Telephone # \_\_\_\_\_

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**PART 1: PERSONAL INFORMATION**

Custodial Parent (CP) Name \_\_\_\_\_ CP WMS Line # \_\_\_\_\_ CP Date of Birth \_\_\_\_\_  
CP Address \_\_\_\_\_ CP SSN \_\_\_\_\_ CP Telephone # \_\_\_\_\_  
Medicaid Case Name \_\_\_\_\_ CP Gross Monthly Income \$ \_\_\_\_\_

**Non Custodial(NCP)/Putative Father (PF) Information**

NCP/PF Name \_\_\_\_\_ NCP/PF SSN \_\_\_\_\_ NCP/PF Date of Birth \_\_\_\_\_  
NCP/PF Address \_\_\_\_\_ NCP/PF Telephone # \_\_\_\_\_

**PART 2: PURPOSE FOR TRANSMITTAL**

- CP court ordered to apply for Public Health coverage for child(ren)
- New MA Application/Reapplication     New Case     New/Updated MA Information     Recovery of Fee-for-Service (FFS) Medicaid Costs
- Addition to Existing Case (see child listed below in Part 3)
- Good Cause Claim Request: Child # \_\_\_\_\_ Date \_\_\_\_\_     Awaiting good cause documentation     Referred to Domestic Violence Liaison  
 Good cause information attached
- Good Cause Reviewed by Medicaid: Child # \_\_\_\_\_     Approved by Medicaid - Date \_\_\_\_\_     Not Approved - Date \_\_\_\_\_
- Child # \_\_\_\_\_ already referred to CSEU and now exempt Reason \_\_\_\_\_
- Temporary Suspension of Medical Support Action due to:  
 Pregnancy - EDC \_\_\_\_\_     NCP in receipt of Medicaid, FHPlus     Other \_\_\_\_\_
- Resume Medical Support Action due to:  
 Pregnancy/Post Partum-End Date \_\_\_\_\_     Other \_\_\_\_\_
- Change in Status/Case (Identify Change): \_\_\_\_\_

**PART 3: CHILD INFORMATION FOR THE NCP NAMED IN PART 1**  Check if additional children are on separate transmittal

*Note: Check box after child's name/line #/CIN only if EXEMPT from Medical Support Requirements*

**CHILD 1**

Child Name \_\_\_\_\_ WMS Line # \_\_\_\_\_ CIN \_\_\_\_\_  EXEMPT

Establish Cash Medical Support Obligation

Coverage type:  FFS  Managed Care (MC) – Monthly Premium: \$ \_\_\_\_\_ Coverage Dates: Start \_\_\_\_\_  Current coverage

Expenses for Prior Periods/Years -  Check if additional years attached

Period/Year: From Date \_\_\_\_\_ To Date \_\_\_\_\_  MC Monthly Premium \$ \_\_\_\_\_ **OR**  FFS expenditures for child: \$ \_\_\_\_\_

Period/Year: From Date \_\_\_\_\_ To Date \_\_\_\_\_  MC Monthly Premium \$ \_\_\_\_\_ **OR**  FFS expenditures for child: \$ \_\_\_\_\_

Pending Managed Care enrollment – effective \_\_\_\_\_ premium \_\_\_\_\_

Recovery of Fee-For-Services Costs due to non-payment of court ordered CMSO: For the period from \_\_\_\_\_ to \_\_\_\_\_

Total paid on behalf of child: \$ \_\_\_\_\_ Total payment(s) received from NCP \$ \_\_\_\_\_ Net due from NCP: \_\_\_\_\_

Billing notice(s) of medical support sent to NCP on: \_\_\_\_\_  Copy of billing notice(s) to NCP attached

**This information is provided for the court to determine the CMSO**

**CHILD 2**

Child Name \_\_\_\_\_ WMS Line # \_\_\_\_\_ CIN \_\_\_\_\_  EXEMPT

Establish Cash Medical Support Obligation

Coverage type:  FFS  Managed Care (MC) – Monthly Premium: \$ \_\_\_\_\_ Coverage Dates: Start \_\_\_\_\_  Current coverage

Expenses for Prior Periods/Years -  Check if additional years attached

Period/Year: From Date \_\_\_\_\_ To Date \_\_\_\_\_  MC Monthly Premium \$ \_\_\_\_\_ **OR**  FFS expenditures for child: \$ \_\_\_\_\_

Period/Year: From Date \_\_\_\_\_ To Date \_\_\_\_\_  MC Monthly Premium \$ \_\_\_\_\_ **OR**  FFS expenditures for child: \$ \_\_\_\_\_

Pending Managed Care enrollment – effective \_\_\_\_\_ premium \_\_\_\_\_

Recovery of Fee-For-Services Costs due to non-payment of court ordered CMSO: For the period from \_\_\_\_\_ to \_\_\_\_\_

Total paid on behalf of child: \$ \_\_\_\_\_ Total payment(s) received from NCP \$ \_\_\_\_\_ Net due from NCP: \_\_\_\_\_

Billing notice(s) of medical support sent to NCP on: \_\_\_\_\_

Copy of billing notice(s) to NCP attached

**This information is provided for the court to determine the CMSO**

*Attach additional pages if more than two children are associated with the NCP*

**PART 4: CERTIFICATION**

I hereby certify that: 1) I am an employee of \_\_\_\_\_, which is required by the NYS Social Services Law to provide correct and complete information from its records in response to requests by the Support Collection Unit; 2) the information in this transmittal is complete and accurate and was taken from records maintained in the Welfare Management System and eMedNY system; 3) I am substantially familiar with the records, systems and recordkeeping practices of the agencies making the records, and such records are created and maintained pursuant to the requirements of the Social Services law and New York State Department of Health regulations; 4) such information is maintained in the regular course of business and it is the regular course of such business to maintain such information; 5) a memorandum or record of said information was made at the time of the act, transaction, occurrence or event, or within a reasonable time thereafter; and 6) this agency routinely relies on these records and record-keeping systems in performing its duties in administering the Medicaid program. I certify that I have been designated by \_\_\_\_\_ for the purpose of making this certification.

**Dated:** \_\_\_\_\_ **Print Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Title:** \_\_\_\_\_