Child Support Enforcement System

Case Action Logs

Add New | Print | Help | Close

Date: [redacted] * Case Number: [redacted] View by: View All Types of Case Action Logs Go

NCP Name: [redacted] CU Name: [redacted]

Displaying 1 to 10 <Previous> 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 <Next>

Log Date	Type	Action	User ID
02/12/2004	PH	CSEA/CSU REC'D T/C FROM MS. MCCORMICK OF OCSE IN ARKANSAS REQUESTING ASSISTANCE IN OBTAINING AN ARREARS CALCULATION (COULD BE MONTH BY MONTH) FROM LOCAL OFFC. MS. MCCORMICK STATED THAT THE CALCULATION IS NEEDED TO DETERMINE HOW MUCH OF A TAX INTERCEPT SHOULD BE APPLIED TO THE CASE AND THE CORRECT BALANCE. FAX SENT TO LOCAL REQUESTING SAME. ARKANSAS' FAX # IS 479-770-5203.....RC	RI3RM2
02/12/2004	PH	INQ. REC'D FROM ROBIN CRUMP OF DHR REQUESTING ARREARS CALCULATION BE SENT TO ARIZONA. WRITER CALLED MS. MCCORMICK OF THE ARIZONA CHILD SUPPORT OFFICE 479 770-5443 TO ASK IF A COPY OF THE PYMT. HISTORY COULD BE USED. MS. MCCORMICK STATE AN AUDIT IS NEEDED DUE TO HER STATE HOLDING LARGE TAX INTERCEPT AND SHE WANT TO MAKE SURE THE FUNDS ARE APPLIED CORRECTLY. MS. MCCORMICK STATE SHE HAS CALLED SEVERAL TIMES FOR THIS INFO. WITH NO SUCCESS. MS. MCCORMICK INFORMED HER REQUEST WILL BE FORWARDED TO THE MANAGER OF THE INTERSTATE UNIT. INQ. ADDED TO PSI LINK AND HARD COPY HAND CARRIED TO MANAGER GAINEY. T.OWENS	RXC30B
02/12/2004	PH	ARIZONA FAX #410 479 770-5203	RXC30B
02/09/2004	PH	NEW AP ADDRESS FROM XXX ADDED TO "VIEW/SELECT AP ADDRESS" SCREEN FOR IRN 471024512 ACK RESP DT: 02/06/2004	SYSTEM
02/03/2004	PH	CO 24U02000082 /24510 MVA STATUS CODE "LN" CHG TO "LS"	SYSTEM
02/01/2004	PH	AP NOT FOUND ON CARES	SYSTEM
01/30/2004	PH	AP SENT TO DPSC FOR LOCATE ASSISTANCE	SYSTEM
01/29/2004	PH	RECEIVED PROTEST FOR DLS FROM NCP, AFTER REVIEWING PAY HISTORY AND NOT RECEIVING PAYMENT SINCE 6/03 NCP IS STILL SUBJECT TO DLS. ATTEMPTED TO CALL NCP AT #'S IN SYSTEM THERE WAS NO ANSWER. IF NCP CALLS OFFICE PLEASE TRANSFER TO CM W/PERMISSION. I.ROBINSON	RXP306
01/28/2004	PH	CS/PH: RECEIVED CALL FROM MRS. MCCORMICK FROM THE OCSE IN ARKANSAS 479-770-5443, REQUESTING A CALL BACK FROM THE INTERSTATE SUPERVISOR, REGARDING A ARREARS AFFIDAVIT SHE REQUESTED 1-YEAR AGO, REF TO INTERSTATE SUP.....DBEN	RXP30A
01/21/2004	PH	EXTERNAL LOCATE REQUEST SENT TO FPLS IRN: 471024512 TRANS NUM: 012974868	SYSTEM

<Previous> 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 <Next>

Add New | Print | Help | Close

Front Side

DHR-Constituent Services

REQUEST FOR HEARING

Fill out this form ONLY if you disagree with a decision concerning your benefits.
If you disagree with the action of the local department, you are entitled to discuss it with a supervisor.
We will help you fill out this form or you can ask for a hearing by calling 1-800-332-6347.

1. Tell us who you are. Fill in the blanks in this box and complete boxes 2-4. Please print clearly.

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code_____ Phone Number ( ) _____

Your local office name: _____ Your Social Security Number: _____

2. Which programs do you want to appeal? (Check all that apply)

Medical Assistance (MA)

_____ Family & Children's MA
_____ Aged, Blind & Disabled MA
_____ Long Term Care MA
Your Representative's Name: _____

_____ Maryland Children's Health Program (MCHP)
Parent or Guardian's Name: _____
___ I receive other benefits
___ I do not receive any other benefits

___ Qualified Medical Beneficiary (QMB/SLMB)

_____Other _____

Family Investment/Social Services Programs

_____Temporary Cash Assistance (TCA)

_____Food Stamps (FS)
_____Purchase of Care (POC – Child Care)
_____Transitional Emergency Medical and Housing Assistance (TEMHA)
_____Foster Care (FC) and/or Adoptions
_____Emergency Assistance (EA)
_____Public Assistance to Adults (PAA)
_____Overpayment of TCA
_____Overissuance of Food Stamps
_____Other _____

3. What are the reasons you want a hearing?

____I was not allowed to apply.
____My application was turned down.
____My application was not handled properly.
____I am not receiving the services that I need.
____I was found not disabled.
____The amount of assistance I receive is wrong.
____My assistance has been incorrectly suspended, reduced, or terminated.
____I do not agree that I should pay back assistance I received.

If you received a notice about this, what is the date on the notice? _____

Why do you want a hearing? Please tell us what happened. _____

_____

4. I understand if I ask for a hearing within 10 days from the date of the notice and I was receiving benefits, I can still get them while I wait for my hearing unless my benefits period ends. I may have to pay back the benefits if I lose my appeal.

☐ Check here if you do **not** want benefits while you wait for your hearing.

_____ _____
Signature Date

FOR AGENCY USE ONLY

Department: _____ Local Office: _____ Date Appeal Received: _____
Case Name: _____ Case Number: _____
Appeal based on notice sent: _____ Effective: _____ Conference held? Y____ N____
Benefits pending? Y____ N____ Reason: _____
Case record attached? Y ____ N ____ Reason: _____
Worker: _____ Supervisor's Approval: _____ Date: _____

FOR APPEAL UNIT USE ONLY

Appeal Rep: _____ Date: _____
Category: _____ Transmitted by: _____

DHR/FIA 334 (Revised 04/02)

Back Side

Office of Administrative Hearings
Administrative Law Building
11101 Gilroy Road
Hunt Valley, MD 21031-1301

Office of Administrative Hearings
Administrative Law Building
11101 Gilroy Road
Hunt Valley, MD 21031-1301

HOW TO HAVE A HEARING IF YOU THINK WE ARE WRONG

- **How do I request a hearing?**
  Use the form on the back of this page.
  Bring the form to your local office
  The name of your local office is in the upper right corner of the notice.
  OR, mail the form to the Office of Administrative Hearings.
  Use the enclosed envelope.
  Make sure the address at the top of this page shows through the envelope window.
  If you don't want to fill out the form
  Come to your local office. We will help you.
  Call your case manager or call 1-800-332-6347.

- **How long do I have to request a hearing?**
  You must ask for a hearing no later than **90 days** after the date of the notice.

- **How can I still get my benefits while I wait for my hearing?**
  If you ask for a hearing no later than **10 days** after the date of the notice and you were getting benefits, you can get your benefits while you wait, unless your benefit period ends.

- **Will I owe any money if I get my benefits while I wait?**
  Yes, if the judge agrees with us and you lose your appeal, you may have to pay back benefits

- **When and where will the hearing be?**
  The Office of Administrative Hearings will send you a notice telling you the time and place of your hearing.

- **Do I have to come to the hearing?**
  Yes, you will lose if you do not come. If you can't come, call the Office of Administrative Hearings and they will let you know how to reschedule your hearing.

- **Can I bring someone to help me or speak for me?**
  You can bring a lawyer, friend or relative. If you want free legal help, call your local office or call Legal Aid at 1-800-999-8904.

- **How can I prepare for the hearing?**
  You can see your file, including your computer file, at your local office and talk with us about this decision. Please call to make an appointment. We will send you our reasons for the decision you are appealing at least 6 days before the hearing.

Si necesita ayuda para llenar el formulario favor de llamar al 1-800-332-6347.

STATE OF MARYLAND
DHMH

Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene
201 W. Preston Street · Baltimore, Maryland 21201
Robert L. Ehrlich, Jr., Governor – Nelson J. Sabatini, Secretary

August 8, 2003

Carol White
7 Limb Court
White Hall, MD 21161

Ruth White has been added to
Older Adults
Services Registry

Dear Carol White:

As you know, the State must suspend accepting new applications for the Older Adults Waiver Registry. By placing Ruth White on the Older Adults Services Registry, a list of individuals interested in receiving waiver services, you have "saved his or her place" for when the State is able to accept new waiver applications. As of 08/07/2003, the Department of Health and Mental Hygiene (DHMH) has added Ruth White to the Older Adults Services Registry. **Participation in the Services Registry does not mean that Ruth is a waiver participant.**

DHMH will contact you at the address and phone number you have provided when a Older Adults slot becomes available. DHMH will make three attempts to contact you (two in writing and one by phone). *If you do not respond to the request in 21 days, Ruth will be removed from the Registry*

It is your responsibility to notify DHMH at the address below of any change to your address and/or phone number. This is very important as we will use this information to contact you regarding services that may be available.

Waiver Services Registry
12051 Indian Creek Court
Beltsville, Maryland 20705-1260
Waiver Services Registry Help Line: 1-866-417-3480 (toll free)

If, for any reason, Ruth is no longer interested in remaining on the Registry, please contact us at 1-866-417-3480 to request that his or her name is removed.

Included with this letter is a Older Adults fact sheet and a list of Service Registry Rights and Responsibilities for you to read.

Sincerely,

Pamela Greene
DHMH Waiver Services Registry Manager

Older Adults Waiver Registry

Maryland's Home and Community Based Services Waiver for Older Adults provides assistance to help older adults continue to live in their homes or in licensed assisted living facilities.

Older Adult Waiver Services

- Personal Care
- Respite Care
- Assisted Living Services
- Senior Center Plus
- Family or Consumer Training
- Person Emergency Response Systems
- Dietitian or Nutritionist Services
- Extended Home Health Care
- Environmental Assessments and Accessibility Adaptations
- Assistive Devices
- Behavior Consultation Services
- Home-Delivered Meals
- Case Management

Additional Services for Waiver Participants:

- Medicaid acute, primary, and preventative services
- Home Health Care
- Transportation
- Prescription drugs
- Medical Day Care
- Durable Medical Equipment and Disposable Medical Supplies

WHO SHOULD APPLY

Maryland residents age 50 and older who need nursing facility level of care.

ELIGIBILITY GUIDELINES

Medical Criteria

Individuals must require a nursing facility level of care based on an assessment from their local health department.

Financial Requirements

- Monthly income of no more than $1656.
- Assets may not exceed $2000 or $2500 (depending on eligibility category).

PERSONS INTERESTED SHOULD

Due to the high demand for Older Adults waiver services but a defined number of available slots, the State must suspend accepting new waiver applications. To reserve your space for when the State can accept new waiver applications, please call the Waiver Services Registry. The Waiver Services Registry is a list of individuals interested in waiver services. To put your name on the Waiver Services Registry:

Call the Registry (toll free) at 1-866-417-3480.

Choice • Independence • Dignity

Living at Home:
MARYLAND
COMMUNITY
CHOICES

Fact Sheet:

Available Waiver Services:

- Attendant Care, including personal assistance services
- Skilled nursing supervision
- Assistive Technology
- Personal emergency response systems
- Environmental accessibility adaptations
- Consumer & Family Training
- Case Management
- Financial management of self-directed employer services

Waiver participants are also eligible to receive Medicaid services which include:

- Physician Care
- Hospital Care
- Pharmacy
- Medical Day Care
- Home Health
- Laboratory Services
- Disposable Medical Supplies & Equipment
- Mental Health Services
- Payment of Medicare premiums, co-payments, and deductibles

The *Living at Home: Maryland Community Choices* waiver provides community services and supports to enable people with physical disabilities to live in their own home.

WHO SHOULD APPLY

Maryland residents with disabilities between the age of 21 and 59, who need nursing facility level of care.

ELIGIBILITY GUIDELINES

Medical Guidelines

Persons must require a nursing facility level of care based on an assessment from your local health department.

Financial Guidelines

A person's income and assets are reviewed to determine financial eligibility for Medical Assistance. For the ***Living at Home: Maryland Community Choices*** waiver, the monthly income of a person may not exceed 300% of SSI benefits ($1,656 monthly in 2003) and the countable assets may not exceed $2,000. Only the income and assets of the person (and assets of any spouse) are considered in determining financial eligibility.

PERSONS INTERESTED SHOULD

If you live in a nursing facility:

You may be able to apply for waiver services. Please call 410-767-7479 for more information.

If you live in the community:

Due to the high demand for ***Living at Home: Maryland Community Choices*** waiver services but a defined number of available slots and funding, the waiver cannot accept new community applicants right now. A Services Registry was developed for interested community individuals. To put your name on the Services Registry for the ***Living at Home: Maryland Community Choices*** waiver, contact the Waiver Services Registry at (toll free) **1-866-417-3480**.

MARYLAND STATE DEPARTMENT OF EDUCATION

Achievement Matters Most

Autism Waiver Registry

*Maryland's Home and Community Based Services Waiver for Children with Autism Spectrum Disorder (**Autism Waiver**) provides support for children with Autism and their families.*

Autism Waiver Services

- Day Habilitation
  - Regular
  - Intensive
  - Intensive Individual Support Services
  - Therapeutic Integration
- Environmental Accessibility Adaptations
- Family Training
- Residential Habilitation
  - Regular
  - Intensive
- Respite Care
- Supported Employment

To be included in the Registry for Maryland's Home and Community Based Services Waiver for Children with Autism Spectrum Disorder:

Call the Registry (toll free) at 1-866-417-3480.

WHO SHOULD APPLY

Maryland residents between the ages of 1 and 21 who are diagnosed with an Autism Spectrum Disorder and are receiving early intervention or special education services.

ELIGIBILITY GUIDELINES

Medical Criteria

An individual's basic and functional activities of daily living or maladaptive behaviors must meet criteria for an institutional level of care. Assistance through waiver services will enable the individual to remain in the home and community.

Financial Requirements

The income and resource criteria of the child alone are considered for financial qualification.

Technical Criteria

- Maryland resident, aged 1 through 21.
- Diagnosed with Autism Spectrum Disorder (DSM-IV, 299.00/299.80).
- If younger than 3 years of age, have an Individualized Family Service Plan (IFSP).
- If older than 3 years of age, have an Individualized Education Program (IEP) with more than 15 hours per week of special education and related services.

PERSONS INTERESTED SHOULD

Autism Waiver services are limited to a certain number of slots. The slots, offered on a "first come, first served" basis, are now full and the waiver is closed to new applicants. Therefore, a **Registry** has been established for those individuals who want to apply for the Autism Waiver when an opening occurs.

MARYLAND DEPARTMENT OF HUMAN RESOURCES
Child Support Enforcement Administration

APPLICATION FOR SUPPORT ENFORCEMENT SERVICES

Support enforcement services include:

- Searching for the other parent
- Legally establishing paternity
- Establishing a court order for child support and health insurance coverage
- Collecting support payments
- Enforcing the court order
- Reviewing and modifying the court order *(All court orders established or modified are subject to periodic review for modification in accordance with the child support guidelines.)*

SECTION I: CASE INFORMATION APPLICANT: DO THE CHILDREN LIVE WITH YOU? ☐ Yes ☐ No

Your Name (First, Middle, Last) _____ Home Phone _____ Business Phone _____

Your Address _____ City _____ State _____ Zip Code _____

Your Social Security Number _____ Your Date of Birth _____

Name of Other Parent (First, Middle, Last) _____ Home Phone _____ Business Phone _____

Other Parent's Address _____ City _____ State _____ Zip Code _____

Other Parent's Social Security Number _____ Other Parent's Date of Birth _____

☐ I believe that disclosure of my address or other identifying information might result in physical or emotional harm to me or my child.

CHILDREN	Name	Date of Birth	Social Security Number
1)			
2)			
3)			
4)			

SECTION II: LEGAL REPRESENTATION

An attorney working in the child support enforcement program represents the Child Support Enforcement Administration of the State of Maryland. The attorney does not represent you or your personal interest and there is no attorney-client relationship between you and the attorney, between you and the child support office, or any employees thereof. Any information you provide may not be treated as confidential, except as provided by law. You may be required to appear as a witness in court. Your failure to appear for court pursuant to an order or subpoena could result in your arrest.

I am applying for support enforcement services on behalf of the child(ren) listed above. I understand that I may have to pay a $25.00 application fee which will not be refundable even if the agency does not succeed in getting support for the child(ren).

Signature _____ Date _____

DO NOT WRITE BELOW THIS LINE

SECTION III: SERVICES REQUIRED

( ) All establishment/enforcement services
( ) Location of other parent
( ) Establishment of paternity
( ) Establishment of court order
( ) Collection/enforcement
( ) Modification
( ) Establishment/enforcement of health insurance only

SECTION IV: VALIDATION

( ) $25 application fee paid.
( ) Fee previously paid.
( ) No fee paid. Explanation: _____
( ) Medical Assistance/MCHP client. Fee does not apply.
( ) TCA applicant-fee deferred.

Validator's Signature (Child Support Staff Person) _____ Title _____ Date _____

MARYLAND DEPARTMENT OF HUMAN RESOURCES
Child Support Enforcement Administration

INFORMATION FOR SUPPORT ENFORCEMENT SERVICES

Complete this form carefully. If you are the custodial parent, complete a separate form for each noncustodial parent from whom you want support. The accuracy of the information you provide may affect how your case is handled. If you do not understand one or more questions on this form, please call your local child support office for assistance.

SECTION I: CUSTODIAL PARENT - (PARENT OR RELATIVE WITH WHOM THE CHILDREN RESIDE.)

Name (First, Middle, Last) _____ Social security number _____

Address _____ Sex _____ Date of Birth _____ Race _____

City _____ State _____ Zip Code _____ Employer _____

Home Phone _____ Business Phone _____ Employer's address _____

SECTION II: SUPPORT

CHILDREN: Name	Social Security Number	Date of Birth	Birthplace	Sex	Race	Relationship to you
1)						
2)						
3)						
4)						

What is your relationship to the other parent?
☐ Never married ☐ Currently married ☐ Separated ☐ Divorced ☐ Other _____

2. Date married: _____ State where married: _____

3. Date and place divorced/separated:

4. If separated, have divorce proceedings been started by a private attorney and/or is court action currently pending?
☐ Yes ☐ No
If yes, please list name, address, and phone number of the attorney and the County and State in which court action is pending: _____

5. If the parents were not married: Has paternity been established for the child(ren)? ☐ Yes ☐ No
Was an "Affidavit of Parentage" signed? ☐ Yes ☐ No

6. If you answered YES to # 5 please list the children for whom paternity has been established or an affidavit signed: _____

7. Do you have a court order for child support from this noncustodial parent?
☐ Yes ☐ No

8. If you answered yes to #5, #6, or #7 above, show where paternity/support was ordered. Include a copy of the order with your application.
County _____ State _____ Court docket # _____ Date of order _____

9. Does the noncustodial parent pay support? ☐ Yes ☐ No

10. If yes or sometimes, to whom does the noncustodial parent pay support?
☐ To you ☐ To a child support agency ☐ Other _____

11. Name and address of the child support agency:

12. Date support last paid: _____ Amount:$

13. Is support paid by a military allotment? ☐ Yes ☐ No

14. Have you ever received Temporary Cash Assistance (TCA, formerly AFDC or "welfare"), Medical Assistance, or previously applied for Child Support Service
☐ Yes ☐ No
If yes, list the County and State: _____ Date of last TCA check if applicable: _____

SECTION III - NONCUSTODIAL PARENT

Name of noncustodial parent (First, Middle, Last) | Alias/Nickname | Home phone | Business phone

Last known address | Date | Social Security Number | Date of birth | Race | Sex

City | State | Zip Code | Eyes | Hair | Height | Weight

Driver's License number | Automobile tag number | Automobile make/model | Year

1. Current or prior military service dates: From _____ to _____

What branch? ☐ Army ☐ Navy ☐ Air Force ☐ Marines ☐ Coast Guard

2. Has the noncustodial parent ever been in jail? ☐ Yes ☐ No Dates: From _____ _____

Name of jail: _____ Address _____

3. Name of noncustodial parent's mother: _____

Mother's maiden name: _____

Address: _____

City | State | Zip Code | Phone number

4. Name of noncustodial parent's father: _____

Address: _____

City | State | Zip Code | Phone number

5. Noncustodial parent's place of birth: _____

6. Noncustodial parent's current or last known employer: _____

Employer's address: _____

Phone number: _____ Employment History - Dates: From _____ to _____

7. Does noncustodial parent receive a pension, disability benefits, social security, or have any other source of income?

☐ Yes ☐ No ☐ Unknown

Income amount: $ _____ From what source: _____

8. Is noncustodial parent a member of a Union/Local? ☐ Yes ☐ No If yes please specify: _____

9. Does noncustodial parent have a license, certificate, registration or permit that is necessary to practice or work in a particular business, occupation or profession? ☐ Yes ☐ No If yes, what type? _____

SECTION IV - HEALTH INSURANCE

1. Is health insurance available to the noncustodial parent? ☐ Yes ☐ No ☐ Unknown

2. Does the noncustodial parent carry health insurance for the child(ren)? ☐ Yes ☐ No

If no, do you want the noncustodial parent to carry health insurance for the child(ren)? ☐ Yes ☐ No

3. Is health insurance available to you through your employer? ☐ Yes ☐ No

4. Do you carry health insurance for the child(ren)? ☐ Yes ☐ No

5. Does anyone else, such as a stepparent or grandparent, carry health insurance for the child(ren)? ☐ Yes ☐ No

If yes, provide name and relationship to the child(ren). _____ Name _____ Relationship

6. Name and address of insurance company covering child(ren). _____

_____

_____

(THIS SIDE FOR OFFICE USE ONLY) IF YOU ARE REQUESTING AN APPEAL, PLEASE COMPLETE THE OTHER SIDE OF THIS FORM.

SEND TO: OFFICE OF ADMINISTRATIVE HEARINGS
ADMINISTRATIVE LAW BUILDING
CLERK'S OFFICE, UNIT B
11101 GILROY ROAD
HUNT VALLEY, MARYLAND 21031
(410) 229-4292

Inquiry Date: (1)_____

TRANSMITTAL/APPEAL FORM - DHR/CSEA

DEPARTMENT OF HUMAN RESOURCES/
LOCAL CHILD SUPPORT ENFORCEMENT OFFICE FOR: (2)_____ /(3)_____
City/County County Code

APPEAL CATEGORY: DHR/CSEA

(4) (ST)TAX INTERCEPT AMOUNT: STATE: $_____ DATE:

(5) (FD)TAX INTERCEPT AMOUNT: FEDERAL: $_____ DATE:

(6) (LO)LOTTERY INTERCEPT: AMOUNT: $_____ DATE:

(7) (PR) PASSPORT DENIAL/REVOCATION DATE: _____

(8) APPELLANT'S NAME: _____ Jr. Sr. /other
(Last) (First) (Middle) Circle One

(9) ADDRESS: _____
Street City/County State Zip Code

(10) APPELLANT'S SOCIAL SECURITY NO.: _____

(11) APPELLANT'S REPRESENTATIVE: _____

ADDRESS: _____

TELEPHONE: _____

(12) AGENCY CASE NO.: _____ /TCA or NTCA CO. CODE:___ CERTIFIED ARREARS:_____ DATE OF CERT.:___

_____ /TCA or NTCA CO. CODE:___ CERTIFIED ARREARS:_____ DATE OF CERT.:___

_____ /TCA or NTCA CO. CODE:___ CERTIFIED ARREARS:_____ DATE OF CERT.:___

(13) OBLIGEE'S NAME:_____ LOCAL AGENCY CASE NO.:_____

ADDRESS:_____
Street City/County State Zip Code

OBLIGEE'S NAME:_____ LOCAL AGENCY CASE NO.:_____

ADDRESS:_____
Street City/County State Zip Code

CHILD SUPPORT APPEAL REQUEST

(TO FILE AN APPEAL, COMPLETE THIS SIDE ONLY. PROVIDE THE REQUESTED INFORMATION, SIGN THIS FORM AND MAIL TO THE OFFICE OF ADMINISTRATIVE HEARINGS - address on reverse.) **INCLUDE A $15.00 FILING FEE** MADE PAYABLE TO THE MARYLAND STATE TREASURER AND A COPY OF THE INTERCEPT NOTICE OR PASSPORT DENIAL/REVOCATION.

I, _____ of _____
(Appellant's name) (Appellant's address)

_____ Telephone No.:_____
City County State Zip Code Home Work

hereby request an appeal of the action taken by the Child Support Enforcement Administration:

I AM APPEALING THE: (Check the appropriate space)

____ INTERCEPTION OF MY STATE INCOME TAX REFUND
____ INTERCEPTION OF MY FEDERAL INCOME TAX REFUND - Failure to return this form within 30 days of the date the notice was sent from the Maryland State Income Tax Division and/or the Internal Revenue Service will result in a dismissal of your appeal unless written documentation of good cause for your delay is included with this form.
____ INTERCEPTION OF MY LOTTERY PRIZE - This form must be filed within 15 days from the date the intercept notice was given or mailed to you by the State Lottery Agency. If the request is not timely, your appeal will be dismissed unless written documentation of good cause for your delay is included with this form.
____ STATE DEPARTMENT'S DENIAL OR REVOCATION OF MY U.S. PASSPORT – This form must be filed within 30 days of receipt of the State Department's notice. If the request is not timely, your appeal will be dismissed unless written documentation of good cause for your delay is included with this form.
____ OTHER (specify)_____

I AM APPEALING BECAUSE:

) I do not owe a support obligation arrearage.
) I do owe a support obligation arrearage, but the amount is now only _____.
) I do owe a support obligation arrearage, but the amount withheld from my State and Federal income tax refunds exceeds the amount owed.
) I do not owe a support obligation arrearage in excess of $5,000 (PASSPORT DENIAL/REVOCATION APPEAL ONLY)
) Other (specify) _____

I WOULD LIKE MY APPEAL TO BE HANDLED IN THE FOLLOWING MANNER:

( ) I wish my appeal to be dealt with by a review of the record and of the evidence I submit with this form. I WAIVE THE RIGHT to a face-to-face hearing. I will be notified when the review will take place. I do not have to appear in person. I will attach documents or include other evidence to support my claim. I understand I have a right to review the local agency's case file. This may be done by contacting the local Child Support Enforcement Office named on the other side of this page. Should I wish to add additional documentation for the Administrative Law Judge to consider, I understand it must be received by the Office of Administrative Hearings (address on reverse) within 5 days prior to the scheduled review.

) I wish my appeal to be dealt with at a hearing. I (with an attorney, if I choose) will be present at the hearing at a date, time and place set by the Office of Administrative Hearings. At that time I will bring any witnesses and evidence I wish to present.

NOTE: If a hearing or record review is not selected, the Office of Administrative Hearings will schedule a record review.

STATE INCOME TAX REFUND APPEALS - ATTACH TO THIS FORM A COPY OF THE LETTER YOU RECEIVED FROM THE MARYLAND STATE INCOME TAX DIVISION (ENTITLED NOTICE OF REVISED INCOME TAX COMPUTATION)

FEDERAL INCOME TAX REFUND APPEALS - ATTACH TO THIS FORM A COPY OF THE LETTER YOU RECEIVED FROM THE INTERNAL REVENUE SERVICE (ENTITLED OVERPAID TAX APPLIED TO PAST-DUE OBLIGATION)

LOTTERY INTERCEPT APPEALS - ATTACH TO THIS FORM A COPY OF THE LETTER YOU RECEIVED FROM THE MARYLAND LOTTERY AGENCY.

PASSPORT DENIAL/REVOCATION APPEALS – ATTACH A COPY OF THE LETTER YOU RECEIVED FROM THE STATE DEPARTMENT.

_____ _____
(SIGNATURE) (DATE)

Mail this appeal request to the Office of Administrative Hearings (address on reverse at top of page)

YOU MUST ATTACH COPIES OF REVISED TAX COMPUTATION LETTER(S) FROM IRS/STATE COMPTROLLER/ LOTTERY AGENCY OR YOUR PASSPORT DENIAL/ REVOCATION LETTER. THIS APPEAL REQUEST MUST BE ACCOMPANIED BY A $15.00 FILING FEE, MADE PAYABLE TO THE MARYLAND STATE TREASURER. A $25.00 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS. FAILURE TO INCLUDE THE $15.00 FILING FEE AND A COPY OF THE INTERCEPT NOTICE OR PASSPORT DENIAL/REVOCATION NOTICE, MAY RESULT IN THE DISMISSAL OF YOUR APPEAL.

(THIS SIDE FOR OFFICE USE ONLY) IF YOU ARE REQUESTING AN APPEAL, PLEASE COMPLETE THE OTHER SIDE OF THIS FORM.

SEND TO: OFFICE OF ADMINISTRATIVE HEARINGS
ADMINISTRATIVE LAW BUILDING
CLERK'S OFFICE, UNIT B
11101 GILROY ROAD
HUNT VALLEY, MARYLAND 21031-1301
(410)-229-4292

TRANSMITTAL/APPEAL FORM - LICENSE SUSPENSION PROGRAMS

TYPE OF LICENSE: MVA BUSINESS OCCUPATIONAL PROFESSIONAL
(Circle One)

Department of Human Resources/
Local Child Support Enforcement Office for: _____
City/County County Code

Appellant's Name: _____, Jr. / Sr. /other
(Last) (First) (Middle)

Address: _____
Street City/County State Zip Code

Appellant's Social Security No.: _____

Driver's License (Soundex) No.: _____ State: _____

Business/Occupational/Professional License No. _____ (if applicable)

Appellant's Representative: _____

Address: _____

_____

Telephone: _____

Agency Case No.: _____ / TCA OR NTCA Co. Code: Certified Arrears _____

Date of Certification _____

Agency Case No.: _____ / TCA OR NTCA Co. Code: Certified Arrears _____

Date of Certification _____

Agency Case No.: _____ / TCA OR NTCA Co. Code: Certified Arrears _____

Date of Certification _____

SEND TO: OFFICE OF ADMINISTRATIVE HEARINGS
ADMINISTRATIVE LAW BUILDING
11101 GILROY ROAD, DRAWER A
HUNT VALLEY, MARYLAND 21031
(410)-229-4100

Inquiry Date:

TRANSMITTAL/APPEAL FORM - CONSUMER REPORTING PROTEST

Department of Human Resources/
Local Child Support Enforcement Office for: _____ / _____
City/County County Code

Appellant's Name: _____ _____ Jr. Sr. /other
(Last) (First) (Middle) Circle One

Address: _____
Street City/County State Zip Code

Appellant's Social Security No.: _____

Appellant's Representative: _____

Address: _____

Telephone: _____

Agency Case No.: _____ /AFDC or NAFDC Co. Code: _ Certified Arrears

Date of Consumer Reporting Certification _____

Agency Case No.: _____ /AFDC or NAFDC Co. Code: ____ Certified Arrears

Date of Consumer Reporting Certification _____

Agency Case No.: _____ /AFDC or NAFDC Co. Code: _ Certified Arrears

Date of Consumer Reporting Certification _____

Obligee's Name: _____ Local Agency Case No.: _____

Address: _____
Street City/County State Zip Code

Obligee's Name: _____ Local Agency Case No.: _____

Address: _____
Street City/County State Zip Code

CHILD SUPPORT CONSUMER REPORTING APPEAL REQUEST

To file an appeal, complete this side only. Provide the requested information, sign this form and mail to the Office of Administrative Hearings - address on reverse. Include a $15.00 filing fee made payable to the Maryland State Treasurer and a copy of the "RESPONSE TO CONSUMER REPORTING PROTEST" (local department's decision in response to your protest).

I, _____ of _____
(appellant's name) (appellant's address)

HOME:
WORK: _____

_____ _____ _____ _____
City County State Zip Telephone No.

hereby request an appeal of the proposed action by the Child Support Enforcement Administration.

- - -

I AM APPEALING BECAUSE:
( ) I do not owe a support obligation arrearage.
( ) I do owe a support obligation arrearage, but the amount is now only _____.
( ) I do owe a support obligation arrearage, but the amount was not 60 days or more in arrears at the time of certification.
( ) Other (specify) _____

I WOULD LIKE MY APPEAL TO BE HANDLED IN THE FOLLOWING MANNER:

I wish my appeal to be dealt with by a review of the record and of the evidence I submit with this form. I WAIVE THE RIGHT to a face-to-face hearing. I will be notified when the review will take place. I will not appear in person. I will attach documents or include other evidence to support my claim. I understand I have a right to review the local agency's case file. This may be done by contacting the local Child Support Enforcement Office named on the other side of this page. Should I wish to add additional documentation for the Administrative Law Judge to consider, I understand it must be received by the Office of Administrative Hearings (address on reverse) within 5 days prior to the scheduled review.

( ) I wish my appeal to be dealt with at a hearing. I (with an attorney, if I choose) will be present at the hearing at a date, time and place set by the Office of Administrative Hearings. At that time I will bring any witnesses and evidence I wish to present.

NOTE: If a hearing or record review is not selected, the Office of Administrative Hearings will schedule a record review.

- -

_____ _____
(signature) (date)

ATTACH TO THIS FORM A COPY OF THE LETTER YOU RECEIVED FROM THE CHILD SUPPORT AGENCY INFORMING YOU OF ITS INTENTION TO REPORT AN ARREARAGE TO A CONSUMER REPORTING AGENCY (ENTITLED "RESPONSE TO CONSUMER REPORTING PROTEST")

Failure to return this form within **30 days** of the date the notice was sent from the Child Support Enforcement Administration will result in a dismissal of your appeal unless written documentation of good cause for your delay is included with this form. **THIS APPEAL REQUEST MUST BE ACCOMPANIED BY A $15.00 FILING FEE, MADE PAYABLE TO THE MARYLAND STATE TREASURER. A $25.00 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS.** Mail this appeal request to the Office of Administrative Hearings (address on reverse at top of page)

YOU MUST ATTACH COPIES OF THE AGENCY'S "RESPONSE TO CONSUMER REPORTING PROTEST"

FAILURE TO INCLUDE THE $15.00 FILING FEE AND A COPY OF THE "RESPONSE TO CONSUMER REPORTING PROTEST" NOTICE MAY RESULT IN THE DISMISSAL OF YOUR APPEAL

LICENSE SUSPENSION PROGRAM

(To file an appeal, complete this side only. Provide the requested information, sign this form and mail to the Office of Administrative Hearings - address on reverse.) Include a $15.00 filing fee made payable to the Maryland State Treasurer and a copy of the "RESPONSE TO PROTEST REFERRAL TO LICENSING AUTHORITY" (local department's decision in response to your protest).

I, _____ of _____
(appellant's name) (appellant's address)

_____ Home #: _____ Work #: _____
City County State Zip Telephone No.

DRIVER'S LICENSE (SOUNDEX) NO.: _____

BUSINESS/OCCUPATIONAL/PROFESSIONAL LICENSE NO.: _____

hereby request an appeal of the proposed action by the Child Support Enforcement Administration.

Failure to return this form within 20 days (MVA appeals) and/or 30 days (Business/Occupational/Professional appeals) of the date the notice was sent from the Child Support Enforcement Administration will result in a dismissal of your appeal unless written documentation of good cause for your delay is included with this form. **THIS APPEAL REQUEST MUST BE ACCOMPANIED BY A $15.00 FILING FEE, MADE PAYABLE TO THE MARYLAND STATE TREASURER. A $25.00 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS.**

I AM APPEALING BECAUSE:

( ) I do not owe a support obligation arrearage.
( ) I do owe a support obligation arrearage, but the amount is now only _____.
( ) I do owe a support obligation arrearage, but the amount was not more than 60 days or more in arrears at the time of certification. (MVA Appeal)
( ) I do owe a support obligation arrearage, but the amount was not more than 120 days or more in arrears at the time of certification. (Bus./Occup./Prof. Appeal)
( ) Other (specify) _____

I WOULD LIKE MY APPEAL TO BE HANDLED IN THE FOLLOWING MANNER:

( ) I wish my appeal to be dealt with by a review of the record and of the evidence I submit with this form. I WAIVE THE RIGHT to a face-to-face hearing. I will be notified when the review will take place. I will not appear in person. I will attach documents or include other evidence to support my claim. I understand I have a right to review the local agency's case file. This may be done by contacting the local Child Support Enforcement Office named on the other side of this page. Should I wish to add additional documentation for the Administrative Law Judge to consider, I understand it must be received by the Office of Administrative Hearings (address on reverse) within 5 days prior to the scheduled review.

( ) I wish my appeal to be dealt with at a hearing. I (with an attorney, if I choose) will be present at the hearing at a date, time and place set by the Office of Administrative Hearings. At that time I will bring any witnesses and evidence I wish to present.

NOTE: If a hearing or record review is not selected, the Office of Administrative Hearings will schedule a record review.

ATTACH TO THIS FORM A COPY OF THE LETTER YOU RECEIVED FROM THE CHILD SUPPORT AGENCY INFORMING YOU OF ITS INTENTION TO REPORT AN ARREARAGE ("Response to Protest Referral to Licensing Authority").

_____ _____
(signature) (date)

Mail this appeal request to the Office of Administrative Hearings (address on reverse at top of page)

YOU MUST ATTACH COPIES OF THE AGENCY'S "RESPONSE TO PROTEST REFERRAL TO LICENSING AUTHORITY"

FAILURE TO INCLUDE THE $15.00 FILING FEE AND A COPY OF THE "RESPONSE TO PROTEST REFERRAL TO LICENSING AUTHORITY" NOTICE MAY RESULT IN THE DISMISSAL OF YOUR APPEAL.

Enrollment forms must be mailed to the address below for processing.

STATE OF MARYLAND
DEPARTMENT OF HUMAN RESOURCES
CHILD SUPPORT ENFORCEMENT ADMINISTRATION

CHILD SUPPORT DIRECT DEPOSIT AUTHORIZATION

SOCIAL SECURITY NUMBER

NAME (please print first, middle initial, last)

HOME ADDRESS (NUMBER & STREET, APT., CITY, STATE, AND ZIP) PLEASE PRINT ALL INFORMATION

I AUTHORIZE THE STATE OF MARYLAND'S STATE TREASURER'S OFFICE (STO) AND THE DEPARTMENT OF HUMAN RESOURCES (DHR) TO TAKE THE FOLLOWING ACTION WITH MY SUPPORT PAYMENT.

(CHECK ONE)

☐ Deposit directly to my checking account
(will take approx. 4 to 6 weeks to implement)

☐ Change bank and/or checking account
(cancel of old account will occur within 21 days of receipt at the Child Support Enforcement Administration (CSEA); you will receive paper checks until Direct Deposit is re-established.)

☐ Discontinue Direct Deposit and issue a paper check instead
(will occur within 21 days)

Bank Name:
(Omit if action 3 is checked)

Copy directly from your personal check. Do not include your check number. Do not use your deposit slip number. Please include a copy of your voided check. Verify carefully.

BANK ROUTING NUMBER

CHECKING ACCOUNT NUMBER

I authorize the State of Maryland to deposit my support monies to the bank and account named above. This authorization is to remain in force until the State of Maryland receives written notification from me of its termination in time and manner that allows the State and the bank a reasonable opportunity to act upon it. In the event that the State of Maryland notifies the bank that funds to which I am not entitled have been deposited to my account in error, I hereby authorize and direct the bank to return said funds to the State as soon as possible. If the funds erroneously deposited to my account have been drawn from that account so that return of those funds by the bank to the State is not possible, I authorize the State to recover those funds by off-setting the amount erroneously paid me from any future payments from the State until the amount of the erroneous deposit has been recovered, in full.

(please initial & date)

DATE SIGNATURE DAYTIME PHONE NO.

Instructions:

- Only one checking account is permitted for Direct Deposit.
- Type or print only (except signature).
- Use black ink only.
- Complete all blocked areas in the top part of form except "FOR CSEA USE ONLY."
- Read authorization and sign the completed form. UNSIGNED OR INCOMPLETE FORMS WILL BE RETURNED.
- If changing your bank and/or checking account, you will receive a paper check until new Direct Deposit becomes effective.
- Send a copy of your DRIVER'S LICENSE, STATE ISSUED IDENTIFICATION CARD, OR A VALID PASSPORT.
- Send completed form along with a "voided check" to:
  Office of Collection Management, Child Support Enforcement Administration, P.O. Box 2563, Baltimore, Maryland 21215-0002.

FOR CSEA USE ONLY	JURISDICTION	
		☐ Copy of Driver's License attached
		☐ Copy of "voided check" attached

CashPay® Visa® · State of Maryland, CSEA Enrollment Form

THE FOLLOWING CONFIDENTIAL INFORMATION IS USED TO ENSURE PROPER IDENTIFICATION

5 0 5 7 4 6

Child Support Recipient Information (Please Print)

Name: First Name	Middle Initial	Last Name	
Address		Apartment#	
City	State	Country	Zip Code
Home Telephone (Area Code Required)	Work Telephone (Area Code Required)	Date of Birth (19YY/MM/DD)	

(Outside US include country and city code for Home and Work numbers.)

Social Security Number	Other legal form of I.D. if Social Security Number not available (i.e. passport# US 1234567

Mother's Maiden Name
(Last name only before married):

I authorize the State of Maryland's STO, and the DHR to deposit my support monies to the CashPay Visa card number named above. This authorization is to remain in force until the CSEA receives written notification from me of its termination in time and manner that allows the CSEA and CashPay a reasonable opportunity to act upon it. In the event that the CSEA notifies CashPay that funds to which I am not entitled have been deposited to my account in error, I hereby, authorize and direct CashPay to return said funds to the CSEA as soon as possible. If the funds erroneously deposited to my account have been drawn from that account so that return of those funds by the CashPay to the CSEA is not possible, I authorize the CSEA to recover those funds by off setting the amount erroneously paid me from any future payments from the CSEA until the amount of the erroneous deposit has been recovered. in full.

Initial & Date

For CSEA Office Use Only

State of Maryland, Child Support Enforcement Agency (All fields must be completed and submitted by a CSEA representative.)

CSEA Office			
CSEA Office Name & Address			
City	State	Country	Zip Code
Phone Number (Area Code Required)	Fax Number (Area Code Required)	Outside US include country and city code for Phone and Fax numbers	

Certification of Company By providing to Bank of America enrollment information to establish a CashPay account for the above-described recipient of payments from the Company (the "Payee"), I certify that the following statements are true and accurate: 1. As of the date of request for a CashPay account, the Payee is entitled to payments issued by the Company, and is otherwise qualified to participate in the CashPay program. 2. That all information provided about the Payee is correct, including the Payee's date of birth, address, and Social Security Number or information from another form of identification issued by a governmental entity 3. That if the Payee is to receive wage payments through a CashPay account, the Payee is legally employable in the United States. (Payee is a US citizen or is a resident alien legally authorized to work in the United States.) 4. That I have given to the Payee the explanatory information for the CashPay program that has been provided by Bank of America.

I agree to notify Bank of America promptly of any changes to the information about the Payee that has been submitted as part of CashPay enrollment. The program will also accept changes to information from the Employee.

Name of Authorized Company Representative | Title | Signature

Please Protect – Confidential Information

1-2003