TARRANT COUNTY DRO
CHILD SUPPORT SERVICES MONITORING PROGRAM
200 E. Weatherford, 2nd Floor, East Wing, FORT WORTH, TX 76161

HEALTH INSURANCE PREMIUMS - UNREIMBURSED
Supporting Documentation

This section applies only to cases in which (a) the Non-Custodial Parent is ordered to provide health insurance, failed to do so, and you, the Custodial Parent, obtained insurance OR (b) the Non-Custodial Parent is ordered to reimburse the cost of health insurance **directly** to you.

Disregard this section if the Non-Custodial Parent is required to make periodic cash medical support payments through the State Disbursement Unit **UNLESS** the Non-Custodial Parent is ordered to pay any cost over the court ordered cash medical support payment **directly** to you.

Disregard this section if you are required to provide health insurance **at your sole cost and expense**.

As the Custodial Parent, it is your responsibility to maintain well-documented and organized records of the amounts expended for the subject child(ren)'s health insurance premiums. In this section the Domestic Relations Office Child Support Monitoring Program (hereinafter DRO/CSMP) will provide a list of documents needed to show proof of insurance coverage and the amounts paid for insurance. You will be provided instructions on how to calculate the actual cost of health insurance for the child(ren) in accordance with the Texas Family Code.

To prove you have/had the subject child(ren) covered by insurance and the amounts expended in premium payments, keep the following documentation in a file folder:

Required Documentation: Proof of health, dental and/or vision insurance through an employer

1. Copy of the policy verifying the names of the dependents and effective dates of coverage
2. Copy of the Cost List verifying the cost for the various plans - Employee Only; Employee + Child; Employee + Family, etc.
3. Copy of each subject child's insurance card
4. Copies of the first and last pay stubs for each effective period of coverage

Required Documentation: Proof of health, dental and/or vision insurance through a private insurance company

1. Copy of the policy verifying the names of the dependents and effective dates of coverage
2. Documentation from the insurance company verifying the cost for the minor dependents only
3. Copy of each subject child's insurance card
4. Copies of cancelled checks OR copies of your bank statements if payments are made via automatic debit OR statements from your insurance provider showing receipt of monthly payments.

Calculating the actual cost of health insurance for the subject child(ren) in accordance with the Texas Family Code

Texas Family Code, §154.182 (b)(3)(b-1), requires the Court to calculate the actual cost of health insurance for the subject child(ren) by first determining if the Custodial Parent has other minor dependents covered under the same health insurance plan. If they are, the Court must divide the total insurance cost to the Custodial

Parent by the total number of minor dependents, including the subject child(ren) covered under the plan. The same formula is used to compute the cost for dental and vision insurance.

EXAMPLE 1

In this example, you provide insurance coverage for yourself and 3 subject children. The plan you selected is for Employee + Family. How do you calculate the cost for the 3 subject children?

Referring to the Cost List provided by your employer, subtract the amount you would be required to pay if you had selected the plan for Employee Only. [NOTE: If the Cost List is given in monthly amounts but you are actually paid semi-monthly, bi-weekly or weekly, you will need to convert the monthly amount on the Cost List to semi-monthly, bi-weekly or weekly, depending on how the premiums are being deducted from your wages]:

Employee + Family	$ 800.00 per month
Subtract the cost for Employee Only	- 168.00
YOUR COST FOR 3 SUBJECT CHILDREN	$ 632.00 per month

EXAMPLE 2

In the first example, your insurance plan covered yourself plus 3 subject children. In this example, you remarry and subsequently add your new spouse and the new child born to you and your new spouse. You now have 2 adults and 4 minor children on your health insurance plan. However, only 3 of the children are the subject of reimbursements for costs. Let's assume you selected the plan for Employee + Family. How do you calculate the cost for the 3 subject children?

Referring to the Cost List for the different plans provided by your employer, start with the cost for Employee + Family. From there, subtract the cost for Employee + Spouse. The difference is the cost for the 4 minor children. Take that amount and divide it by the number of minor children to get the "per child" cost of health insurance. Then, take the "per child" amount and multiply that by the number of subject children. [NOTE: If the Cost List is given in monthly amounts but you are actually paid semi-monthly, bi-weekly or weekly, you will need to convert the monthly amount on the Cost List to semi-monthly, bi-weekly or weekly, depending on how the premiums are being deducted from your wages]:

Employee + Family	$ 800.00 per month
Subtract the cost for Employee + Spouse	- 375.00
Equals the cost for 4 minor children	425.00 per month
Divided that by total number of children	÷ 4
Equals the cost per child	106.25 per month
Multiply by the number of subject children	x 3
YOUR COST FOR 3 SUBJECT CHILDREN	$ 318.75 PER MONTH

Tracking the amounts expended for the subject child(ren)'s insurance

Once you determine the actual cost of health insurance for the subject child(ren), keep track of the premium payments. You can use the spreadsheet provided at the end of this section or re-create the following spreadsheet on your own computer using either Excel or Word. If you set up the spreadsheet on your computer you must set it up to look exactly like the example shown below.

List only the amounts paid for the subject child(ren). List each premium payment separately. DO NOT lump an entire year's worth of premium payments together.

Date Paid	Amount Paid for Health Insurance	Amount Paid for Dental Insurance	Amount Paid for Vision Insurance

Keep a separate spreadsheet listing any reimbursements you receive from the Non-Custodial Parent:

Insurance Reimb. Date Paid	Insurance Reimb. Amount Paid

Methods for Notifying the Non-Custodial Parent of the Cost for the Subject Child(ren)'s Insurance

It is important that you notify the Non-Custodial Parent of the cost for the subject child(ren)'s insurance and that you include proof of the coverage and cost. Proof should include a copy of the insurance policy or certification, Cost List, schedule of benefits, insurance cards and any other forms necessary for the use of the insurance. Include a cover letter explaining how you computed the cost for the subject child(ren)'s coverage. Keep a copy of your letter as proof that you notified the Non-Custodial Parent of the amounts due. Below are several methods for notifying the Non-Custodial Parent:

1. Our Family Wizard – this method must be ordered by the court
2. If the court did not order the parties to use Our Family Wizard, the DRO/CSMP requires you to send the following items to the Non-Custodial Parent by **certified mail, return receipt requested:**
    - A copy of the spreadsheet
    - A cover letter notifying the Non-Custodial Parent of his/her portion
    - Copies of the documentation listed above under the section entitled Required Documentation

If the certified mail is returned to you unclaimed, DO NOT open it. You may follow-up by providing additional copies using, either first class mail, email or hand-delivery.

Documents provided to our office

If this office begins the process of a Child Support Review or initiating legal action, you will be given a maximum time of **two weeks** to submit the following items to the DRO/CSMP using the mailing address provided above:

1. If you were ordered to use Our Family Wizard, send the copies of any notices sent to the Non- Custodial Parent regarding insurance reimbursements, including any attachments (proof).

2. If you are not ordered to use Our Family Wizard, send the following documents:
    - Copy of your cover letter to the Non-Custodial Parent
    - Copy of your spreadsheet
    - Copies of the documentation listed above under the section entitled Required Documentation
    - Copies of the postmarked Certified Mail receipt and corresponding return receipt (green card) and/or any unopened, unclaimed certified mail.

******** NOTICE TO THE CUSTODIAL PARENT ********

The Non-Custodial Parent must owe more than $500 in unreimbursed medical expense for this office to attempt enforcement. You may seek assistance from a private attorney at any time for help with unreimbursed medical expense.

If the Non-Custodial Parent owes reimbursement for insurance premiums, it is VERY IMPORTANT that you submit your medical packet to this office in the format and time- period set out below.

If this office begins the process of a Child Support Review or initiating legal action, you will be given a maximum time of TWO WEEKS to submit the medical packet to the DRO/CSMP at the mailing address provided above. Therefore, it is imperative that you keep records of the subject child(ren)'s cost for health/dental/vision insurance up-to-date at all times.

Medical packets must be submitted in the exact format shown below. Any medical packets that are not properly prepared will be returned to you and the DRO/CSMP will NOT include any requests for reimbursement in its legal proceedings.

If a final order is signed without addressing insurance premium reimbursements existing at the time of the order, the Court may later rule you WAIVED your right to collect reimbursement from the Non-Custodial Parent.

These are the minimum requirements. If your case goes to litigation, additional information may be required.

To complete this document, EITHER print out this page and hand-write the information (make additional copies of this page as needed) OR copy and paste this spreadsheet onto a blank Word document; type the information directly onto the document (edit to add additional rows as needed); and save the finished spreadsheet on your computer as a Word document. Don't forget to print and send your spreadsheet along with proof to NCP.

NCP Name: **CP Name:**

OAG No.: **Child Support Acct#:** **Cause No.:**

**** List only the amounts paid for the subject child. List each premium payment separately ****

Date Premium Paid by Custodial Parent	Amount Paid Medical Insurance	Amount Paid Dental Insurance	Amount Paid Vision Insurance	Date Notice Last Sent to Non-Custodial Parent

Total amount paid by the Custodial Parent **$** _____

Total amount paid/reimbursed by the Non-Custodial Parent **$** _____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

OAG Case #: _____
NCP/Obligor Name: _____
CP/Obligee Name: _____

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made (separate authorization is required for each patient):

Full Name: _____ Date of Birth:_____
Address: _____, _____,
_____, _____
Phone: (_____) _____

Information regarding covered entity authorized to disclose this information:

Name: Tarrant County Child Support Services/Local Rule 991
Address: 200 East Weatherford Street, 2nd Floor East, Fort Worth, Texas 76196
Phone: 817-884-1475
Cause No.: _____

Information regarding person or entity who can receive and use this information:

Name: Tarrant County Child Support Services/Local Rule 991
DISTRICT COURT AND ALL NECESSARY COURT PERSONNEL

Name: _____OR _____'S
AUTHORIZED REPRESENTATIVE _____
Address: _____City: _____State: _____Zip Code: _____

Phone: (_____)_____Fax : _____

Reason for release of information: At the request of the undersigned individual, the Tarrant County Child Support Services will seek reimbursement for the incurred medical expenses. This authorization is limited to the pursuit of the medical expenses in Cause No.
Specific information to be disclosed regarding the incurred medical expenses:

- Medical Record from ___/___/____to the present
- Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers
- Other: _____

Include: (Indicate by *Initialing*)

_____ Drug, Alcohol, or Substance Abuse Records
_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)
_____ Mental Health Records (Except Psychotherapy Notes)
_____ Genetic Information (Including Genetic Test Results)

The individual signing this form agrees and acknowledges as follows:

(i) Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) Effective Time Period: This authorization shall be in effect until entry of a final judgment and exhaustion of any appellate deadlines regarding the individual's claims for reimbursement for the incurred medical expenses in the Medical/Dental Expenses Tracking Sheet(s).
If you prefer a specific date to revoke this authorization, please indicate: Month: _____Day: _____Year:____

(iii) Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the covered entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) Special Information: This authorization may include disclosure of information relating to DRUG, ALCOHOL, and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION only if
I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

(vi) Copy of this Authorization: The covered entity is required to provide the individual with a copy of this signed authorization upon request.

I certify that I personally consented to all medical treatment covered by this Authorization on behalf of the patient named in this Authorization.

Patient/Legal Representative: _____Date: ____/____/_____
Patient/Legal Representative Printed Name: _____
If Legal Representative, relationship to Patient: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment. See TEX. FAM. CODE § 32.003.

Signature of Minor Patient (if applicable): _____Date: ____/____/_____