TARRANT COUNTY DRO
CHILD SUPPORT SERVICES MONITORING PROGRAM
200 E. Weatherford, 2nd Floor, East Wing, Fort Worth, TX 76196

OUT-OF-POCKET HEALTHCARE EXPENSES - UNREIMBURSED
Supporting Documentation

This section applies if the Non-Custodial Parent is ordered to pay a portion of the subject child(ren)'s health care expenses.

As the Custodial Parent, you are responsible for maintaining well-documented and organized records of the amounts expended for each subject child's health care expenses. In this section a list of documents needed to show proof of health care expenses and a method to track your child(ren)'s health care expenses using an Excel spreadsheet or Word document will be provided. The Non-Custodial Parent must owe more than $500 in unreimbursed medical expenses for this office to attempt enforcement.

Required Documentation: Health Care Expenses

Create file folders to store documents relating to the subject child(ren)'s health care expenses. The Domestic Relations Office Child Support Monitoring Program (hereinafter DRO/CSMP) requires the following documentation:

1. Physician's Statement. Usually, this is the receipt given to you at the doctor's office at the time of services. The Physician's Statement must clearly state the (a) Patient's Name; (b) Date of Services; and (c) Patient's Payment. NOTE: Credit card receipts without billing statement will not be accepted.

2. For prescriptions, keep copies of the prescription labels OR obtain a Patient History printout from your Pharmacy.

3. If you have an ongoing expense like braces, please provide the full contract with monthly payment obligation and the final statement showing paid in full.

4. Proof of payment can consist of copies of the (a) credit card receipts; (b) debit card receipts; (c) cancelled checks, (not the carbon copy); and/or (d) bank statements for automatic withdrawals. Bank statements must clearly identify the Payee. Any receipts must be attached to the corresponding billing statement from the health care provider.

Tracking the amounts expended for the subject child(ren)'s health care expenses

The DRO/CSMP requires you to keep track of each subject child's health care expenses. Please utilize the spreadsheet provided at the end of this section or re-create the spreadsheet 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. It is important that you list each expense separately in chronological order by the Date of Services. For example, if you take all 3 subject children to the doctor on the same day, list them separately on the spreadsheet; if you get 3 prescriptions filled on the same day, list them separately on the spreadsheet. Create a separate spreadsheet/Word document to track any reimbursements you receive from the Non-Custodial Parent.

The DRO/CSMP strongly recommends you update this spreadsheet each time a health care expense is incurred for a child. Keeping your spreadsheet up to date at all times will prevent any unnecessary delays in scheduling a Child Support Review conference or filing legal action.

If your order does not provide a specific timeline, the DRO/CSMP strongly recommends you give the Non-Custodial Parent notice at least once a month. Below are several methods for notifying the Non-Custodial Parent:

1. Appclose, Our Family Wizard, or email – 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:**

    a. A copy of the spreadsheet
    b. A cover letter notifying the Non-Custodial Parent of his/her portion; and
    c. 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 the DRO/CSMP

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 at the mailing address provided above:

1. If you were ordered to use Appclose, Our Family Wizard or email, send the DRO/CSMP copies of any notices sent to the Non-Custodial Parent regarding health care expenses, including any attachments (proof).

2. If you are not ordered to use Appclose, Our Family Wizard, or email send the DRO/CSMP the following documents:

    a. Copy of your cover letter to the Non-Custodial Parent
    b. Copy of your spreadsheet
    c. Copies of the documentation listed above under the section entitled Required Documentation
    d. Copies of the postmarked Certified Mail receipt and/or any unopened, unclaimed certified mail.

Sample Spreadsheet

In this example, the Non-Custodial Parent is ordered to pay fifty percent (50%) of the subject children's health care expenses:

Count	Date of Services	Purpose	Child	Amount Paid by Custodial Parent	Date Copy Last Sent to Non-Custodial Parent
1	10-21-10	medical care	Jeff	$250.00	11-1-10
2	10-21-10	prescription	Jeff	180.00	11-1-10
3	10-28-10	orthodontic	Kay	500.00	11-1-10
4	11-14-10	vision care	Jeff	690.00	12-1-10

Total amount paid by Custodial Parent	$ 2120.00
Non-Custodial Parent's percentage owed (50%)	$ 1060.00
Amount paid by Non-Custodial Parent	$ 50.00
*Balance due from Non-Custodial Parent	$ 1010.00

* *NCP must owe > $500 to seek enforcement from our office*

Label your supporting documentation to match the Count on your spreadsheet, i.e.:

- any documents supporting Count 1 must be labeled **#1**
- any documents supporting Count 2 must be labeled **#2**
- any documents supporting Count 3 must be labeled **#3** etc.

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

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

If the Non-Custodial Parent owes reimbursement for health care expenses, 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 each subject child's health care expenses 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 reimbursement for health care expenses 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 each health care expense in order by Date. List each health care expense separately ****

Count	Date of Services	Purpose	Child	Amount Paid by Custodial Parent	Date Copy Last Sent to NCP

Total amount paid by Custodial Parent (CP) **$** _____

NCP's portion – 50% (or amount specified in order) of the above **$** _____

Total amount paid/reimbursed by Non-Custodial Parent (NCP) **$** _____

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: ____/____/_____