[CURRENT_DATE]

CSE Case Number: [CSE_CASE_NUMBER]
Participant Name:
[PARTICIPANT_PR_NAME]
SSN: [PR_WORKING_SSN_MASK
DOB: [PARTICIPANT_PR_DOB]
Driver License: [PARTICIPANT_DL_NUMBEF
Last Known Address:
[PARTICIPANT_LAST_KNOWN_ADDRESS]

Attention Personnel Department:

This office has received information that [PARTICIPANT_PR_NAME] is working or has worked for your company/business. Please choose an option and complete the checklist below within 30 calendar days of the date you received this letter:

Option 1

☐ Complete the enclosed form about this person.
☐ Sign the certification.
☐ Return the completed form to this address:
[OFFICE_NAME]
[OFFICE_MAIL_ADDRESS_SINGLE_LINE]

Option 2

Alternatively, instead of completing the enclosed form, you may provide a printout or other attachment(s) containing all of the information requested on the form. If you choose this option, please note:

☐ All of the information must be included. Partial compliance is non-compliance and subject to penalty.
☐ You must still sign the certification.

If you have any questions or need additional information, please visit the Employer Resource Center at ***http://www.childsupport.ca.gov/employer-resource-center*** or call Customer Connect at [PHONE_CSSC]. Please update your company demographics at ***http://www.childsupport.ca.gov/employer-update-contact-information-form***. Persons with hearing or speech impairments, please call the TTY number at [CUSTOMER_CONNECT_TTY_PHONE].

California Family Code section 17512 requires employers and labor organizations to provide employment, income and health insurance information about their employees and independent contractors to child support agencies within 30 calendar days upon written request. This written information request is made pursuant to California Family Code section 17512. Please provide the information requested within 30 calendar days of the date you received this letter.

Sincerely,

[WORKER_NAME]
[WORKER_TITLE]

Enclosure

This page intentionally left blank.

WAGE AND INSURANCE VERIFICATION

DCSS 0230 (06/20/2021)

CSE Case Number: [CSE_CASE_NUMBER]
Participant Name: [PARTICIPANT_PR_NAME]
Employer Name: [EMPLOYER_NAME]

EMPLOYEE/CASE PARTICIPANT IDENTIFICATION AND CONTACT INFORMATION *(If you have different information, write new information in the blank spaces.)*

Name: [PARTICIPANT_PR_NAME]	Social Security Number: [PR_WORKING_SSN]	Date of Birth: [PARTICIPANT_PR_DC
Address: [PARTICIPANT_LAST_KNOWN_ADDRESS]		Phone Number: [PARTICIPANT_HOME

EMPLOYEE WORK STATUS *(Check all applicable boxes and fill in requested information.)*

☐ **Never employed** *(If never employed, no need to complete form further. Just sign the certification on page 3 and return entire form.)*

☐ **Currently employed:** ☐ Part-time ☐ Full-time ☐ Seasonal Usual season start date: _____

☐ **Independent Contractor** Usual season end date: _____

Occupation:

☐ **No longer employed** Last date employed: _____

Reason for termination of employment: _____

New employer name:	New employer address:

Has your business received an Income Withholding Order for support for this employee/Independent Contractor? ☐ Yes ☐ No

What income tax filing status does employee report? ☐ Single ☐ Head of Household ☐ Married	How many dependents does employee claim for income tax withholding purposes?

EMPLOYEE/INDEPENDENT CONTRACTOR EARNINGS

Next Pay Date *(Month, Day, Year):*

Pay Frequency *(Check one):* ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

Hourly Rate *(If applicable):* $ _____ Number of Hours: _____

Monthly Deduction *For Mandatory Retirement:* $ _____ *For Mandatory Union Dues:* $ _____

Union Name:	Union Local Number:

Period of Employment: *From (Month, Day, Year):* *To (Month, Day, Year):*

Please complete employee's/independent contractor's earnings for the past 12 months or attach a copy of payroll/1099 earnings for those months. If the employee has worked less than 12 months, provide the information for the number of months employee did have earnings.

☐ Check if copy of payroll/1099 earnings is attached. ☐ Check if employee/independent contractor has worked less than 12 months.

Month / Year	Gross	Month / Year	Gross	Month / Year	Gross
January	$	July	$	January	$
February	$	August	$	February	$
March	$	September	$	March	$
April	$	October	$	April	$
May	$	November	$	May	$
June	$	December	$	June	$

RETRNBARCDFLD BARCODEFIELD

[USER ID]

WAGE AND INSURANCE VERIFICATION

DCSS 0230 (06/20/2021)

CSE Case Number: [CSE_CASE_NUMBER]
Participant Name: [PARTICIPANT_PR_NAME]
Employer Name: [EMPLOYER_NAME]

HEALTH INSURANCE INFORMATION *(**Note to the preparer:** If more than one plan is available to the employee, **please list the lowest cost insurance plan** available for the employee, even if it is different than the plan the employee is presently enrolled in.)*

Check all applicable boxes:

☐ No health insurance is available to: ☐ Employee ☐ Employee's dependents

☐ Health insurance is available at **no cost** for: ☐ Employee ☐ Employee's dependents

☐ **Total** cost to the employee of ***lowest cost*** available health insurance **for employee and all of employee's insured dependents**:

Cost reported is for period: ☐ Annual ☐ Monthly ☐ Two Weeks ☐ Weekly ☐ Other

☐ Medical: $_____ ☐ Dental: $_____ ☐ Vision: $_____ ☐ Other: $_____

DEPENDENT INFORMATION *(List names of all of employee's insured dependents. Add a sheet of paper if more space needed.)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

POLICY INFORMATION

	MEDICAL	DENTAL	VISION
Insurance Co. Name:			
Mailing Address:			
Phone Number:			
Policy Number:			
Effective Date:			
Expiration Date:			

WAGE AND INSURANCE VERIFICATION

DCSS 0230 (06/20/2021)

CSE Case Number: [CSE_CASE_NUMBER]
Participant Name: [PARTICIPANT_PR_NAME]
Employer Name: [EMPLOYER_NAME]

CERTIFICATION OF RECORD

I have personally completed this form, or printed and attached records containing **all** of the employee's earnings and benefits information requested in this form, from the payroll records in my custody and control. I am personally aware such records are kept in the regular course of business and that entries therein are made at or about the time of the condition or event. I have compared the records with the above *Wage and Insurance Verification* (DCSS 0230) and know the information I am supplying to be accurate.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Print Name	Signature	Executed on *(Date)*
Job Title	Address	
Name of Company or Business Organization		
Telephone Number	Email Address	
Fax Number	FEIN (Do not provide SSN)	