SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Medical Support Referral (Optional)

You have the option to ask the Dept. of Social Services (DSS) Office of Child Support Enforcement (OCSE) to collect medical or other support from an absent or non-custodial parent. A non-custodial parent is a parent who does not have custody of the child as the result of a court order. The option to complete this form does not affect your Medicaid eligibility determination. If you apply for this service and the OCSE agrees to collect medical or other support from a non-custodial parent, your cooperation with the OCSE is mandatory. Additionally, your continued cooperation is mandatory if you are already involved with the OCSE from prior applications for SNAP (food stamps) or Temporary Assistance for Needy Families (TANF) benefits. If you think that cooperating to collect medical or other support will harm you or your children, you can request to opt out.

You have the option to complete this Medical Support Referral form, return it to us and we will send the information to DSS for you. **If you need to add additional children, please make a copy of this page before proceeding.**

Do you want to share the following information about your child's non-custodial parent with DSS to help with Child Support enforcement? ☐ **Yes** ☐ **No** If Yes, please complete the section below.

Child 1 Name (First, Middle, Last)	**Child 1's Custodial Parent** Name (First, Middle, Last)

Child 1's Non-Custodial Parent Name (First, Middle, Last)		Date of Birth	Social Security Number		☐ Male ☐ Female
Street Address (residence)	City	State	ZIP	Phone	
Mailing Address (if different from residence)	City	State	ZIP	Phone	
Employer Name					
Employer Street Address	City	State	ZIP	Phone	

Race Code: ☐

01-White/Caucasian **02**-Black/African American **03**-Multi-Race
04-Federally Recognized Native American **05**-Other Native American
06-Alaska Native **07**-Asian **08**-Other/Unknown
09 Native Hawaiian/Pacific Islander **10**-Hispanic

Child 2 Name (First, Middle, Last)	**Child 2's Custodial Parent** Name (First, Middle, Last)

Leave blank if same non-custodial parent as Child 1

Child 2's Non-Custodial Parent Name (First, Middle, Last)		Date of Birth	Social Security Number		☐ Male ☐ Female
Street Address (residence)	City	State	ZIP	Phone	
Mailing Address (if different from residence)	City	State	ZIP	Phone	
Employer Name					
Employer Street Address	City	State	ZIP	Phone	

Race Code: ☐

01-White/Caucasian **02**-Black/African American **03**-Multi-Race
04-Federally Recognized Native American **05**-Other Native American
06-Alaska Native **07**-Asian **08**-Other/Unknown
09 Native Hawaiian/Pacific Islander **10**-Hispanic

Child 3 Name (First, Middle, Last)

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Child 3's Custodial Parent Name (First, Middle, Last)

Child 3's Non-Custodial Parent Name (First, Middle, Last) | Date of Birth | Social Security Number | ☐ Male ☐ Female

Leave blank if same non-custodial parent as Child 2

Street Address (residence)	City	State	ZIP	Phone
Mailing Address (if different from residence)	City	State	ZIP	Phone
Employer Name				
Employer Street Address	City	State	ZIP	Phone

Race Code: ☐

01-White/Caucasian **02**-Black/African American **03**-Multi-Race
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06-Alaska Native **07**-Asian **08**-Other/Unknown
09 Native Hawaiian/Pacific Islander **10**-Hispanic

Child 4 Name (First, Middle, Last, Suffix)

Child 4's Custodial Parent Name (First, Middle, Last)

Child 4's Non-Custodial Parent Name (First, Middle, Last) | Date of Birth | Social Security Number | ☐ Male ☐ Female

Leave blank if same non-custodial parent as Child 3

Street Address (residence)	City	State	ZIP	Phone
Mailing Address (if different from residence)	City	State	ZIP	Phone
Employer Name				
Employer Street Address	City	State	ZIP	Phone

Race Code: ☐

01-White/Caucasian **02**-Black/African American **03**-Multi-Race
04-Federally Recognized Native American **05**-Other Native American
06-Alaska Native **07**-Asian **08**-Other/Unknown
09 Native Hawaiian/Pacific Islander **10**-Hispanic

Your Name (Please Print)

Your Signature | Date (mm/dd/yyyy)

Mail your signed form to:

SCDHHS - Central Mail
PO Box 100101
Columbia SC 29202-3101

If you have questions about this form or need assistance completing it, please call our Member Contact Center at 1-888-549 0820.