

## Medical Assistance Only - Election of Support Enforcement Services

CERTIFICATION PERIOD (FOR DEPARTMENTAL USE ONLY)		CASE NUMBER (FOR DEPARTMENTAL USE ONLY)
OPEN:	CLOSE:	
YOUR FULL NAME (PLEASE PRINT)		
NONCUSTODIAL PARENT'S FULL NAME (THIS IS THE PERSON WHO HAS A REQUIREMENT TO PAY CHILD SUPPORT) (PLEASE PRINT)		
IF PREGNANT - ESTIMATED DELIVERY DATE		

The Division of Child Support (DCS) will provide full child support enforcement services until:

1. You mark either box 1, 2 and 2a, or 3 below.
2. You sign this form.
3. DCS receives and processes this form.

If the noncustodial parent's dependent children receive medical assistance benefits, DCS must try to enforce and collect medical support owed for those children. Medical support includes health insurance coverage and health care costs. If the children's father is not identified, a court must try to determine the father of the dependent children.

**MARK THE BOX THAT LISTS THE CHILD SUPPORT ENFORCEMENT SERVICES YOU WANT. SIGN THIS FORM.**

1.  I want to have paternity established if necessary and medical support establishment and enforcement services only. I do not want full child support enforcement services.
2.  I am pregnant and I receive medical assistance benefits.
  - a.  I do not want full child support enforcement services. I do not want DCS to contact me for information during my pregnancy.
  - b.  I want full child support enforcement services. I do not want DCS to contact me for information during my pregnancy.
3.  I want medical support establishment and enforcement services only. I do not want full child support enforcement services. Paternity is not in question.
  - I understand that DCS will keep medical support payments to repay the state for medical costs. DCS will send other payments to me.
4.  I want full child support enforcement services. DCS may contact me at any time. Full child support enforcement services may include any of the following as needed:
 

• Child support	• Spousal support	• Medical support
• Child care support	• Paternity establishment	• Review of my case for modification

Mail the completed original form to: DIVISION OF CHILD SUPPORT  
PO BOX 9008  
OLYMPIA WA 98507-9008

**I declare that I read and understand the services I chose above.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

No person because of race, color, national origin, creed, religion, sex, age, or disability, shall be discriminated against in employment, services, or any aspect of the program's activities. This form is available in alternative formats upon request.