

ASSIGNMENT OF RIGHTS AND AUTHORIZATION TO COLLECT SUPPORT

Noncustodial Parent:

Child(ren):

IV-D Number: _____

I, _____, assign to the Cabinet for Health and Family Services (CHFS) medical support owed for the child not to exceed the amount of Medicaid payments made on behalf of the child.

I hereby authorize CHFS, to collect on my behalf all current and/or past-due child support, medical support and spousal support payable to me for the benefit of myself and/or my minor child(ren).

I authorize any and all current or past-due sums of child, medical and/or spousal support which are owed to me to be paid to CHFS and guarantee these monies have not already been paid.

I further understand that the Cabinet for Health and Family Services will assess a nonrefundable annual fee of \$35.00 for child support services when \$550.00 has been disbursed during the federal fiscal year.

CHFS shall distribute any and all payments received according to federal and state laws.

SIGNATURE

DATE

Return to:
