

Instructions for Completing the Support Collection Payment Request (DHS-820)

This attachment provides instructions for completing a DHS-820 to request refunds of collections sent to the state or county in error for agency placement or blood tests. The DHS-820 must not be used for Family Independence Program (FIP), birth expense or medical support refunds.

Entries on the DHS-820 must be typed or printed, and must be legible to ensure accurate processing for refunds. Do not complete shaded areas.

Item Number	Item and Instruction
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1. **Central Office Use.** Leave blank.
2. **Load Number.** Enter 999999.
3. **Program.** Leave blank.
4. **County Number.** Enter the two-digit county code where the customer lives.
5. **Customer's Name.** Enter the customer's name, last name first.

On requests for refunds of blood test recoveries, enter the name of the custodial party (CP), guardian, or Family Independence Program (FIP)¹ case grantee.

If the refund request is for an agency placement recovery (Title IV-E Foster Care, or State Ward Charge Back), enter the Agency Placement Person ID for the **child** associated with the Agency Placement Case ID (to be entered in Item 6, *MDHHS Case Number*). If there are additional Agency Placement Person IDs for that Case ID, enter them in Item 33, *Additional Explanation*.

6. **MDHHS Case Number.** Enter the correct Michigan Department of Health and Human Services (MDHHS) assistance case number (AC-ID).

If the collection was reported with an incorrect AC-ID, list that incorrect number in Item 33. This assists the department in locating the collection records.

¹ FIP is also known as Temporary Assistance for Needy Families (TANF).

If collections were deposited in error on behalf of a family that never received assistance, and there is no AC-ID, enter "None."

If the refund request is for an agency placement recovery (Title IV-E Foster Care, or State Ward Charge Back), enter the Agency Placement Case ID.

- 7-9 Leave blank.
10. **Pay to.** Enter a checkmark to indicate the refund is payable to the Friend of the Court (FOC).
- 10A. **Payee Name.** Enter the name of the FOC to whom the refund is payable.
- 10B-E **Payee Address.** Enter the current and complete mailing address of the payee (FOC).
11. **FOC.** Enter the two-digit county number of the FOC.
12. **FIPS Number.** Enter the seven-digit FIPS Code of the FOC.
13. **Court Case Number.** Enter the correct court order number. If the collection was reported with an incorrect court order number, list that incorrect number in Item 33.
14. **Payer Name.** Enter the full name, last name first, of the non-custodial parent (NCP) making support payments.
15. **Refund Reason.** Place a checkmark in the box next to the primary reason for the refund request.

Refund reasons and definitions are as follows:

FIP Closed-Decert Eff. (Discontinued – DO NOT USE)

Person Off FIP-Decert Eff. (Discontinued – DO NOT USE)

MDHHS Overpaid

Collections payable to the family were misdirected to MDHHS.

- Submit the court order with the DHS-820 if the obligation is less than actual figures.
- If the payment history began prior to MiCSES, provide history information from the Child Support Enforcement

System (CSES), if this information was not provided with the DHS-820.

Account Overpaid

A payer's account is overpaid.

- For example, charges may have been set up incorrectly in MiCSES. Provide an explanation of the error on the DHS-820.

Note: For refunds requested due to overpayments, identify the most recent collections retained by the state that are sufficient to cover the amount of the overpayment.

Case Number Error

An error in the AC-ID or court case number resulted in the collection being sent to the state in error, or applied to the wrong individual's case/docket.

Provide an explanation on the DHS-820. Produce the *Court Order Information* report for both docket numbers to verify the payments posted. In Item 13, enter the wrong docket number, and in Item 33, enter the correct docket number.

Collection Type Error

Money sent to the state was reported with the wrong collection type. For example, a payment was applied as an agency placement payment, but should have been distributed as a child support payment to the family.

NSF

A payment credited to a payer's account was voided due to non-sufficient funds.

Offset in Error

A tax refund was offset in error.

Other – Specify

Specify the reason for the request in Item 33, *Additional Explanation*. For example, write "CCCF overpaid" (County Child Care Fund) if money was incorrectly disbursed to the county.

16. Type of Collection

16A. Leave blank.

- 16B. **Other Collections.** Complete Item 16B by entering a checkmark next to the box that identifies the type of collection requested for refund (e.g., blood test).

For foster care, check *IV-E Court or State Ward* if the child's debt type was CC, CS or PB. Check *Specify* and write "CCCF" if the child's debt type was County-Funded Placement (WF).

Note: **Do not** select "Medical" since this form is **discontinued** and no longer used for medical support and birth expense refunds.

Collection Period or Date. Complete this item if the refund is a request for blood test or State Ward Charge Back (i.e., collections identified in Other Collections).

List the date of the collection requested for refund, or, if the request is for collections for several consecutive months, list the time period for the request.

17. Leave blank.
- 18A. Leave blank.
19. **Collection Amount.** Enter the amount of the collection(s) from which all or a portion is requested for refund.
20. **Amount of Refund Requested.** Enter the amount of the collection(s) requested for refund.
21. **Adjustment.** Leave blank. The department will enter a negative adjustment in this item if the amount requested for refund exceeds the amount of the collection retained by the state and available for refund.
22. **Amount Approved.** Leave blank. If an adjustment appears in Item 21, this item will identify the amount authorized for refund from the collection.
23. **Totals.** Enter the total amount requested for refund in Item 23A. Leave 23B and 23C blank.
- 24-32 Leave blank.
33. **Additional Explanation.** Use this item to record the following information:

Enter "Foster Care Support Refund Request" if the IV-D worker used the *Specify* option in either Box 15 or Box 16B.

If a collection was reported with an incorrect AC-ID and/or court order number, identify the incorrect number(s) in this item. List the correct AC-ID and court order number in Items 6 and 13, respectively.

If the refund request is for an agency placement recovery (Title IV-E Foster Care, or State Ward Charge Back) with multiple children, enter Agency Placement Person IDs associated with the corresponding Agency Placement Case ID (see Item 5) for each child.

34. **Authorized Signature.** Sign the requester's name.
35. **Agency.** Enter a checkmark in the box next to "FOC."
36. **County.** Enter the county name for the primary work location, or county where the case is located.
37. **Phone Number.** Enter the phone number(s).
38. **Date.** Enter the date the form is completed.

Distribution. Send the original to the appropriate processing unit identified below, and keep a copy for the case file.

Send requests for refunds of:

- Blood test recoveries to:

Michigan Department of Health and Human Services
Office of Child Support
201 N. Washington Square
P.O. Box 30478
Lansing, MI 48909

- Agency placement recoveries to:

Michigan Department of Health and Human Services
Accounts Receivable Unit - Government Benefits
Grand Tower 8th Floor
P.O. Box 30025
Lansing, MI 48909

Note: For money incorrectly disbursed to the CCCF, IV-D staff will submit the DHS-820 to the entity in the county that received the incorrect payment. (This is the address in MiCSES for the “WF” Check Recipient Type 3.)