IOWA Health and Human Services

EMPLOYMENT AND HEALTH INSURANCE QUESTIONNAIRE

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Date: _____
Case Number: _____
Child Support Services
_____
_____
_____
_____
_____
Phone: _____
Fax: _____

Employee Name:
_____

Social Security Number (SSN):
_____

Dear Employer:

We are attempting to gather information about _____. Our information indicates this person is currently or was formerly contracted or employed by you. As required in Iowa Code 252B.9(1)(c) and in 42 USC 666(c)(1)(C), please provide as much information as you can regarding _____'s employment and health insurance coverage.

Employment Information about _____:

Home Address (current ☐ or last known ☐):		
Current/last known phone number:	Date of Birth:	SSN (if different than above):
Gross Monthly Salary: $	Year to Date Gross Wages: $	Prior Year Gross Wages: $
Length of employment: Start: End:	Last Pay Date: (for current or former employee)	
Average number of hours worked per week:	Hourly rate: $	Overtime (OT) rate: $
Is OT paid on a regular basis? Yes ☐ No ☐ Please provide details regarding OT (likely to continue, etc.):		
Pay Frequency: Weekly: ☐ Biweekly: ☐ Semimonthly: ☐ Monthly: ☐		

_____'s Work Site Address:	Is this employee a contractor? Yes ☐ No ☐
Is this a seasonal employee? If yes, provide details. Yes ☐ No ☐	
Are taxes withheld from the employee's pay? Federal taxes: Yes ☐ No ☐ State taxes: Yes ☐ No ☐ Social Security taxes (FICA): Yes ☐ No ☐	
Union Dues: $ _____ per _____	Mandatory Pension: $ _____ per _____
If no longer employed at this company, please provide the name and address of the current employer (if known):	
Reason for Termination:	

Health Insurance Coverage Information

Federal Regulations (45 CFR 303.30) require that we obtain health insurance information about dependent(s). Iowa law says that we must seek a health benefit plan, if a plan is available. A plan is available if it is accessible (no service area limitations, or the dependent(s) live within 30 miles or 30 minutes of a network primary care provider) and the cost is reasonable (5% of gross income or less).

Does your company offer a health benefit plan? Yes ☐ No ☐

Please provide the employee's share of the premium for each plan, **even if no one is enrolled**.

Employee's Single Monthly Premium $ _____ Is the employee enrolled? Yes ☐ No ☐

Employee's Family Monthly Premium $ _____ Are dependents enrolled? Yes ☐ No ☐

If yes, total number of dependents enrolled: _____

Employee+Child(ren) Monthly Premium $ _____ Is employee/child(ren) enrolled? Yes ☐ No ☐

If yes, total number of dependents enrolled: _____

Is the family health benefit plan available to dependent(s)? Yes ☐ No ☐

If not available at this time, please provide the date it will be available: _____

Does the plan(s) have service area limitations? Yes ☐ No ☐

If yes, please provide your website address or attach written information so the Child Support Services office can review the health benefit plan(s) to determine if a plan is accessible to the dependent(s).

Signature of person completing form:	Date:
Telephone number of person completing form:	Employer email address: