Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-3628-ENG 2-20

Notice of denial of child support good cause exemption

DATE	
CUSTODIAL PARENT	NON-CUSTODIAL PARENT
PROGRAM	CASE NUMBER

We reviewed and **denied** your claim for a good cause exemption from the requirement to cooperate with the child support agency for:

NAME OF CHILD	DATE OF BIRTH
NAME OF CHILD	DATE OF BIRTH
NAME OF CHILD	DATE OF BIRTH
NAME OF CHILD	DATE OF BIRTH

because:

☐ You did not submit evidence to support a claim of good cause. (Legal Authority: Minnesota Statutes, Section 256.741, Subdivision 11)

☐ The evidence you submitted did not support a claim of good cause. (Legal Authority: Minnesota Statutes, Section 256.741, Subdivision 12)

☐ You did not submit new evidence to support your claim, as we requested. We were unable to make a decision to continue your good cause exemption without current evidence to support your claim. (Legal Authority: Minnesota Statutes, Section 256.741, Subdivision 13)

☐ You verbally withdrew your good cause claim, but you did not complete and return the form we sent you indicating that decision.

☐ You reported that the other parent is now living in your household.

Now that your claim was denied

Now that your good cause claim was denied, you have the following options:

- You may cooperate with the child support agency to establish paternity/obtain child support. Cooperation may include establishing paternity, collecting medical support, and obtaining basic support and child care support. The county child support office will provide information about the requirements of cooperation.
- You may choose to not receive assistance for you and your children.
- You may request closure of your assistance case(s) and ask the child support agency to close its case for (this child) (these children).
- Under some programs, you may choose to not receive assistance for some children. Contact your public assistance program for more information.

- For Health Care Assistance only, you may ask to remove yourself from the assistance case(s). Your child(ren) will continue to be eligible. However, we will notify the county child support agency, which may start to enforce medical support without your cooperation.
- If you would like the county good cause committee to reconsider your good cause claim, you can request a conference with the good cause committee at the phone number listed below. Contact your public assistance program for information or to request a conference. **You must make a request for a conference within 30 days of receiving this notice.**
- You may refuse to cooperate with child support. However, the county child support agency will notify the public assistance program of your failure to cooperate. As a result, you could be removed from the public assistance case, you could be sanctioned, or your case could be closed. Upon receiving notice that the county agency intends to deny, end or reduce your public assistance benefits due to your failure to cooperate with the child support agency, you have the right to appeal the proposed denial, termination or reduction of public assistance benefits by requesting a state agency hearing. Instructions regarding requesting a state agency hearing will be provided with the county notice, however, you must make the request for the hearing within 30 days of receiving that notice.

Requesting a conference

You can try to resolve the issues by requesting a conference with the good cause committee. The conference can be held by telephone or in person. **You must make a request for a conference within 30 days of receiving this notice.** To request a conference, contact the good cause committee at:

CONTACT PERSON	PHONE NUMBER

COMMENTS

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ያስተውሉ፡ ይህንን ዶኩመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆነ፡ የጉዳዮን ሰራተኛ ይጠይቁ ወይም በሰልክ ቁጥር 1-844-217-3547 ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ သင့်လူမှုရေးအလုပ်သမား အားမေးမြန်း ခြင်းသို့ မဟုတ် 1-844-217-3563 ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ ប្រើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលខេ 1-888-468-3787 ។

請注意，如果您需要免費協助傳譯這份文件，請告訴您的工作人員或撥打 1-844-217-3564。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, demandez à votre agent chargé du traitement de cas ou appelez le 1-844-217-3548.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ဟ်သူဉ်ဟ်သးဘဉ်တက့ါ. ဖဲနမ့ါ်လိဉ်ဘဉ်တါ်မၤစၢၤကလီလၢတါ်ကကျိုးထံဝဲဇဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်,သံကွါ်ဘဉ်ပှၤဂ့ါ်ဝီအပှၤမၤစၢၤတါ်လၢနဂီါ်မ့တမ့ါ်ကိးဘဉ် 1-844-217-3549 တက့ါ.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 담당자에게 문의하시거나 1-844-217-3565으로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກຳກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1 (8-16)

ADA Advisory

For accessible formats of this information, ask your county worker. For assistance with additional equal access to human services, contact your county's ADA coordinator. ADA4 (2-18)

Civil Rights Notice

Discrimination is against the law. The Minnesota Department of Human Services (DHS) does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- marital status
- age
- disability
- sex
- political beliefs

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by a social services agency.

Contact **DHS** directly only if you have a **discrimination** complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
651-539-1100 (voice)
1-800-657-3704 (toll free)
711 or 1-800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion

Contact the **OCR** directly to file a complaint:

Director, U.S. Department of Health and Human Services' Office for Civil Rights
200 Independence Avenue SW, Room 509F
HHH Building
Washington, DC 20201
1-800-368-1019 (voice)
1-800-537-7697 (TDD)
Complaint Portal:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf