

Ohio Department of Medicaid  
**COURT ORDERED SUPPORT AND PUBLIC LIABILITY CERTIFICATION**

I, \_\_\_\_\_,

Print Full Legal Name

\_\_\_\_\_ Social Security Number

do hereby agree that as a condition of my initial employment, satisfactory completion of my probationary period, and continued employment with the State of Ohio, that if I am now or ever become subject to a lawful agreement or court order requiring me to pay child support, spousal support or alimony, or any other support ordered by a court having jurisdiction, I will pay all monies or provide other support as required by such agreement or order in a timely fashion as provided in such agreement or order. In the event any arrearage exists at the time of my initial employment or occurs subsequently, I agree to liquidate satisfactorily such arrearage in accordance with any subsequent agreement or order.

I declare that all information provided is true and correct to the best of my knowledge. I understand that any false statements made here could result in the rescission of an offer of employment or in disciplinary action up to and including removal. I state that:

1. I  am /  am not in default of any court order requiring me to pay child support, spousal support or alimony, or any other support ordered by a court having jurisdiction. If currently in default, I  am /  am not in an approved plan to correct the default.

I hereby authorize the Ohio Department of Medicaid (ODM) to access my child support case information, if any, in order to verify compliance with any child support, spousal support, or any order that I am ordered to pay support. My SETS case number is \_\_\_\_\_.

2. I  am /  am not indebted to the State of Ohio or other government entity for any payment for taxes and/or benefits (i.e., Workers' Compensation, Unemployment Compensation, Medicare, Medicaid, etc.). If currently in default, I  am /  am not in an approved plan to correct the debt. ODM may contact the appropriate agencies and/or the Attorney General's Office to verify my certification to this statement.

3. I understand that if I am currently receiving benefits from the State of Ohio or other government entity to which, by accepting employment with ODM, I become ineligible, I will immediately report my employment to said entity and return any benefits paid for the period after the commencement date of my employment with ODM.

Signature of Affiant		Date
Witness Signature	Witness Name ( <i>printed</i> )	Date