Georgia Department of Human Resources
TANF / FAMILY MEDICAID/ CHILD SUPPORT SERVICES
COMPLIANCE AGREEMENT

_____ County Department of Family and Children Services

For DFCS Use Only	
_____ Grantee Relative Name	_____ Date Mailed / Given
_____ Grantee Relative Address	_____ Case Manager / Load #
_____ SUCCESS AU ID #	_____ Telephone / Fax Number

Date of Compliance Request: _____

I understand that TANF cash assistance was terminated for my assistance unit and/or my Family Medicaid benefits were terminated because I failed to cooperate with the Office of Child Support Services (OCSS).

In order to receive TANF cash assistance and/or Family Medicaid benefits again, I understand that I must cooperate with the OCSS by assisting in one or more of the following activities:

1. Locating the absent parent(s) of the children for whom I receive assistance
2. Establishing legal paternity, if necessary, and
3. Establishing or enforcing a child support order.

I agree to contact the OCSS within 10 calendar days of the date of this compliance agreement and if necessary, schedule an appointment. I understand that if I fail to cooperate with the OCSS, my family and I will not be eligible for TANF cash assistance, and I will not be eligible for Family Medicaid benefits.

The telephone number of the local office of child support services is _____

_____. I must

be in compliance with the office of child support services no later than

_____/___/___.

Applicant's Signature: _____ Email Address: _____

Applicant's Telephone Number: _____ Applicant's Cell Number: _____

Case manager's Signature: _____

For OCSS Use Only
❑ Cooperated on
❑ Did not Cooperate as of
❑ Did not contact OCSS as of
Comments: _____

OCSS Agent / Case Manager's Signature _____ Date _____

OCSS Case # _____

Form 5706 (Rev.01/2007)