

**OCSE Insurance Match Program  
State Participation Election Form**

1. The State of \_\_\_\_\_ elects to participate in the OCSE  
(Insert State Name)  
Insurance Match Program.

2. Please select one of the following regarding your State's minimum arrears threshold for  
an obligor to be eligible for the OCSE Insurance Match Program:

\_\_\_\_ Use the \$25 default as the minimum arrears threshold.

\_\_\_\_ Use \_\_\_\_\_ as the minimum arrears threshold.  
(Insert Dollar Amount)

\_\_\_\_\_  
IV-D Director or Designee  
State Child Support Enforcement Agency

\_\_\_\_\_  
Date

Return completed form to:

Sherry Grigsby, Employer Services & Special Matching  
Program Manager  
Email: [sherry.grigsby@acf.hhs.gov](mailto:sherry.grigsby@acf.hhs.gov)  
Fax: (202) 401-6114