

Re: Child Support Case No	,	
Non-Custodial Parent	,	
Custodian	,	
Children:		
Support Order Date:	Date of Last Review:	

REQUEST FOR REVIEW OF CHILD SUPPORT ORDER

Instructions

Use this form to ask the Division of Child Support Services (DCSS) to review your case for possible modification (change).

Except for your signature, print your responses. Use a black or blue ink ball point pen only.

Sign and return all required forms to your Child Support Services office.

Attach copies of your last two federal income tax returns and copies of your last three pay stubs. If you do not have tax returns or pay stubs, attach a separate sheet explaining why:

Complete and return the following forms:

- This form. Return both pages.
- Personal/Financial Affidavit (3 pages),
- Confidential Information Form,
- Waiver of Personal Service,
- Daycare Verification (if applicable).

Please provide a certified copy of your order. Failure to provide a certified copy may result in termination of the review.

I want DCSS to review my support order for modification because: (check the boxes below that affect your case):

- \Box My wages changed.
- At least one of the children in my case turns 18 within 6 months.
- □ The other parent's wages changed.
- □ At least one of the children in my case lives in a different home.
- □ A health insurance requirement needs to be added to my order.
- $\hfill\square$ I am disabled or imprisoned.
- Other (give details):

Note: A modification review may be conducted for persons who receive TANF benefits without the request of either parent.

If you have any questions, please call 1-877-423-4746. Or you may view your case information on the Customer Service Online website at <u>https://services.georgia.gov/dhr/cspp/do/Logon</u> First time users are required to register to obtain a user ID and password. Your IRN is required to register.

I understand and agree that:

• All forms must be signed and notarized where required or they will be returned to you, which may cause delays or possible termination of the modification review.

- DCSS only reviews child support and health insurance modifications for the children.
- DCSS does not represent me or the other party to my support order.

DCSS uses information I provide to establish, modify, or enforce child support.

• After DCSS reviews my request, DCSS will determine if my case meets requirements for modification.

• Both parties have the right to have an attorney represent them in court under the provision of GA law O.C.G.A. 19-6-19.

- The judge decides the start date.
- I have the right to ask a court to modify or adjust my support order on my own.

• My modified or adjusted support order can result in higher, lower or remain unchanged support payments.

• Must notify DCSS of any changes to my name, address, phone number(s) or any other information that is needed to proceed with my request for a review and modification.

• I understand that a \$100 modification fee will be required if my monthly gross income (before taxes) is equal to or greater than \$1,000 and I requested the review and modification. The fee is waived if I am receiving TANF. If I receive Medicaid for my children and not for myself and my monthly gross income (before taxes) is equal to or greater than \$1000 per month the fee must be paid. The fee, if applicable, will be required when the review is complete and the order is adopted by the court.

• I understand that I am responsible for providing proof of my income and expenses. Failure to provide the required information within the specified time frame(s) may result in termination of the review process or an Agency Recommendation that may adversely affect my interests.

• I understand that legal documents including the Agency Recommendation and a petition will be personally served to me by my local sheriff's department or process server at my place of residence unless I sign and return the attached Waiver of Personal Service.

Under the penalty of perjury, I do hereby swear and affirm that the information I provided is accurate and true to the best of my knowledge. I understand the criminal penalties for making false statements and false swearing under Georgia Law, O.C.G.A §16-10-71 is punishable by a fine of not more than \$1,000 or by imprisonment of one year or more, or both. I do hereby attest to the truthfulness of the information provided.

Date

Signature

Visit our web site at: http://dcss.dhs.georgia.gov/

No person because of race, color, national origin, creed, religion, sex, age, or disability, shall be discriminated against in employment, services, or any aspect of the program's activities. This form is available in alternative formats upon request.

FOR CHILD SUPPORT AGENCY USE ONLY			
Agency representative's Signature Date			
Agency Street Address	City	State	Zip Code

Review and Modification Checklist

Please note that you are responsible for providing proof of any information that you wish to be considered in a review of your court order. If you fail to do so or fail to respond, the review will be based on information available to us. The Division of Child Services is not responsible for proving your allegations. You must obtain this proof.

When completing the documents attached to the Notice of Child Support Review, the following must be provided, if applicable:

Income Verification:

- Pay stubs (last five or more)
- _____ Tax records (last two years)

If you receive Social Security benefits, you will need to provide the following:

- _____ Proof from the Social Security Administration showing type benefits received
- _____ Proof from the Social Security Administration showing the monthly amount received
- Proof from the Social Security Administration showing that child(ren) is/are eligible for benefits from your account, and if so the date that child(ren) became eligible and type benefit(s) received (IF APPLICABLE)
- Proof from the Social Security Administration that a claim is pending, including the date that your claim was filed and the date of any hearing
- _____ Proof of military pension (VA BENEFITS) or disability including the date(s) received and the monthly amount

If you are paying child support under a pre-existing order to another individual, state or foreign jurisdiction, you must provide: (Note: Information for child support being paid through Georgia DCSS is not required)

- ____ Copy of the court order
- _____ Payment history detailing payments made to any court, individual, or agency.

If you have qualified children (excluding stepchildren) in your home, you must show proof by providing the following:

- ____ Copies of birth certificate(s)
- _____ Adoption order, if applicable.
- ____ School records

If you are providing medical insurance for the child(ren)

- _____ Copy of the insurance card verifying coverage
- _____ Insurance company name, address, phone number, sponsoring employer, (if group coverage) name or the person(s) providing insurance
- _____ Group number and policy number
- ____ Names of covered members
- _____ Total cost of insurance and frequency (monthly, weekly, bi-weekly, etc.)
- _____ Cost of insurance for the child or children's portion on this case

If you are providing vision and /or dental coverage

- _____ Copy of the insurance card verifying coverage
- _____ Insurance company name, address, phone number, sponsoring employer, (if group coverage) name or the person(s) providing insurance.
- _____ Group number and policy number
- ____ Names of covered members
- _____ Total cost of insurance and frequency (monthly, weekly, bi-weekly, etc.)
- _____ Cost of insurance for the child or children's portion on this case

If you have life insurance with the child(ren) as a beneficiary

- Proof of life insurance from your insurance company with the child or children listed as beneficiaries
- Proof of the monthly cost of the life insurance

If you have expenses associated for work related child care

_____ The attached Day Care Verification Form must be completed by your provider.

If you have expenses for other activities for the child(ren) such as music, choir, art, or sports, etc., you will need to provide evidence of these costs per month.

____ Statement from school, or provider showing the costs of participating in these activities. These must show the cost for each child being considered in the case being reviewed.

If you have extraordinary medical expenses and/or educational expenses. You must provide:

Proof from the medical and /or educational provider showing the amount(s) being paid per child each month and the balance left owing on the debt.

If you are the non-custodial parent and seeking a review based on job loss or financial instability:

- _____ Separation notice from my last employer detailing my circumstances for job loss
- _____ Statement detailing the reasons for your current financial instability if currently employed
- _____ If you are currently disabled, please provide a statement from your doctor noting if your disability is permanent or temporary. If temporary, we will need the date of your anticipated return to work.

PROVIDE DOCUMENTS THAT MAY DEMONSTRATE A BASIS FOR A DEVIATION IN THE AMOUNT OF CHILD SUPPORT. THESE DOCUMENTS MAY INCLUDE, BUT ARE NOT LIMITED TO:

- **a.)** An order of visitation. To be a deviation it may have to be extended visitation that is more than the usual amount. Joint or shared physical custody;
- **b.)** Insurance for the child, including health, dental, vision or life insurance where the child is the beneficiary;
- c.) Work related child care costs;
- d.) High income of either parent;
- e.) Low income of either parent (demonstrating extreme economic hardship or no earning capacity);
- f.) Substantial Travel Expenses for visitation;
- **g.)** Alimony;
- h.) Mortgage payments made to the custodial parent for the benefit of the child;
- i.) Permanency or Foster Care Plan;
- **j.)** Extraordinary expenses for the child(ren) like educational costs as well as special expenses for raising the child and extraordinary medical expenses.

Your response must be completed and notarized where appropriate. If you fail to do so, the review may be delayed or terminated without further notice.

PERSONAL / FINANCIAL AFFIDAVIT

CUSTODIAL PARENT []

NON CUSTODIAL PARENT [] NON PARENT CUSTODIAN []

PERSONAL INFORMATION:

Your	name:
------	-------

Last	First		Middle		Maiden
Other married names, r	iicknames, etc:				
Marital status: [_] Single	e [_] Married S	pouse:			[_] Divorced
Social Security Number	 ·		Sex: [_] Male	[_] Female	
Date of birth:/	_/ Place of birth	:			
		City	State	County	Country
Eyes:	_Hair:	Weight:	Height:	ftin	
Home address:					
Stree	t address	City	State	County	Zip
Mailing address:	t address	City	State	County	Zip
					·
At this address since: _ Home phone #:					
Home phone #:					
Last permanent addres	s: Street address	City	State	County	Zip
Driver's license no:	State:	5		•	·
License tag:			•		
FEDERAL BENEFI [_] Receives social securit [_] Receives military pens Does the child(ren) receiv If yes, type, benefit amour	ty disability [_] R ion or disability [_] N e benefits from parent's	eceives SSI [_] ever received ANY of account? [_] Yes [_]	Receives survivor to the above benefits	;	
ADOPTION / FOSTER C	ARE:				
[_] Currently receive [] Reunification / Foste			\$		
YOUR EMPLOYMENT:					
[_] Unemployed [_] * If you are self-employed yo	Self-employed u MUST provide a copy o	Type of business: f all applicable tax return		ess, company and/or	proprietorship.
IF UNEMPLOYED: (please Reason for job termination:		r separation notice) [[]Laid Off []C		_ to//	
Did you receive: [] Disabili	ty from:// to/_	_/ [] Settlen	nent Amount: \$		
Employer:			Job title:		
Contact person:			_ Work phor	ne no: ()	
Employer address: Street a	address	City		State	County Zip
Employed from/		2			County Zip
GROSS income: \$,					

INSURANCE INFORMATION:

Do you provide health insur	ance? [_]Yes [_] No Total	number of people inc	luded in policy?	Monthly	Cost: \$
Each child's portion: \$	Who is currently	covered by Health Ins	surance?		
Insurance company name:_					
Insurance company phone	no.: (Poli	cy / Group No.:_		
		ity			
Street address Do you provide life insuranc Do you provide dental insur	e with the child on this case	as the beneficiary? [•	t: \$
Do you provide vision insura	ance? [_]Yes [_] No Mont	hly Cost for children i	ncluded in this c	ase: \$	
NAME OF BANK / CREDIT	UNION:				
	·····		t type & no.:		
	·····		t type & no.:		
FAMILY HISTORY: [Note: eve			Dharaaaaa	(
Your mother:					
Date of birth://_	Place of birth:		[_] Decease	ea on/	/
Address:					
Street address		City	State	County	Zip
Your father:			Phone no.:	()	
Date of birth://	Place of birth:		[_] Decease	ed on/	
Address:					
Street address		City	State	County	Zip
Other close relative/Famil	y/Friends:		F	Relationship:	
Address:		0.1		0	
Street address		City	State	County	Zip
Phone number or other con	tact address:				
MILITARY STATUS: [_] Ne Branch:	ever in military serviceService no:	[_] Active [_] Ro Entry date:/_	etired [_ / Discharg	_] Discharged je date:/_	
HAVE YOU EVER BEEN IN [] Prison history [] F					
Incarcerated from/		•	oend: / /		
Institution name:					
Institution address:					
YOUR TANF (WELFARE) I [_] Never on TANF [_] Receives Medicaid Only	HISTORY: [_] Currently on TA	NF [_] Formerly of	on TANF [_]	History unkn	own
PREVIOUS EMPLOYMENT Provide city, state & employ		ses are not required.			
EDUCATIONAL HISTORY: Schools (High school, Trade	e, Colleges) attended:				
Name	Street	City	State	Zip	Phone Number

Your Financial Summary

Gross Income Source (before taxes)	Average Monthly Gross Amount	Expense Source	Average Monthly Gross Amount
Salary / Wages (do not include TANF)	\$	Rent or mortgage payment	\$
Commissions, fees & tips	\$	Utilities (electric, natural / propane gas, telephone)	\$
Self-Employment Income	\$	Child care (proof is required)	\$
[Refer to O.C.G.A. §19-6-15 (f)(1)(B) for details]	Ť	Alimony Paid	\$
Bonuses	\$	Food	\$
Overtime Payments	\$	Medical bills or expenses (not covered by insurance) (proof is required)	\$
Severance Pay	\$	Probation / parole fines	\$
Recurring income from Pensions or retirement plans	\$	Vehicle payment	\$
Interest Income	\$	Clothing	\$
Income from dividends	\$	Transportation/Visitation costs	\$
Trust income	\$	Child support paid by previous court order	\$
Income from annuities	\$	Property taxes	\$
Capital Gains	\$	Recreation	\$
Social Security Disability or Retirement (Do not include SSI or payment for children)	\$	Insurance (Health) (proof is required)	\$
Worker's Compensation benefits	\$	Insurance (Life) (proof is required)	\$
Unemployment Compensation benefits	\$	Insurance (Automobile, Homeowners)	\$
Judgments from Personal Injury or other Civil Cases	\$	Insurance (Dental/Vision) (proof is required)	\$
Gifts (cash or other gifts that can be converted to cash)	\$	Bankruptcy	\$
Prizes / Lottery winnings	\$	Extraordinary Educational Expenses	\$
Alimony & maintenance from persons not on this case	\$	(i.e., tuition, books, room & board) (<i>proof is required</i>)	
Assets which are used for support of family	\$	Child's extraordinary medical expenses	\$
Fringe Benefits (if significantly reduce living expenses)	\$	(co-pays, deductibles) (proof is required)	
Any other income including Imputed Income:	\$	Special expenses for child rearing	\$
(Do not include means-tested public assistance, such as TANF or Food Stamps)		(i.e., camp, band, music, art, clubs) (proof is required)	
		Other:	\$
TOTAL MONTHLY GROSS INCOME:	\$	TOTAL MONTHLY EXPENSES:	\$

I understand the criminal penalties for making false statements and false swearing under O.C.G.A. §16-10-71 and do hereby attest to the truthfulness of the information provided. So sworn and affirmed:

Your signature:	SSN Date://
Notary Public signature:	Commission expiration date://

NOTARY SEAL:

	Confidential Information Form		
Divorce/Separation//Non-paren	• •		
Information Change (Check if			
	-	s in effect protecting L	the non-custodial parent
the custodial parent	the children.	41	
		the parties <u>is require</u> n Form to list additi	onal parties or children)
[] Non-Custodial Parent		lial Parent	[] Non-Parent Custodian
Name (Last, First, Middle)	[]		
Race	S	Sex	Birth date
Driver's Lic. or Identicard (# and	Stata)	Employer	
Driver's Lie. of Identicard (# and	State)	Employer	
Mailing Address (P.O. Box/Stree	t, City, State, Zip)	Employer Address a	and Phone Number:
Relationship to Child(ren)		Your Phone Number:	
Your E-mail address:			
The following information <u>is required</u> if there are children involved in the proceeding.			
1) Child's Name (Last, First, Middle)			
Child's Race/Sex/Birthdate			
Child's Present Address or Where	eabouts		
2) Child's Name (Last, First, Mid	dle)		
Child's Race/Sex/Birthdate			
Child's Present Address or Whereabouts			
Child's Tresent Address of Where	cabouts		
List the names and present	addresses of the pe	rsons with whom the	e child(ren) lived during the
List the names and present addresses of the persons with whom the child(ren) lived during the			
last five years:			

List the names and present addresses of any person besides you and the respondent who has physical custody of, or claims rights of custody or visitation with, the child(ren):

Please list qualified children: (your l	biological children residing in your home):	
1) Child's name:	2) Child's name:	
Residential Address (Street, City, State, Zip)	Residential Address (Street, City, State, Zip)	
Date of Birth:	Date of Birth:	
Please list children in which you have court ordered child support:		
1) Child's name:	1) Child's name:	
County of Order and Civil Action Number	County of Order and Civil Action Number	
Support Order Amount: \$	Support Order Amount: \$	

Additional information:

Additional Confidential Information Form attached.

I certify under penalty of perjury under the laws of the state of Georgia that the above information is true and accurate concerning myself and is accurate to the best of my knowledge as to the other party, or is unavailable. The information is unavailable because

Signed on _____ (Date) at _____ (City and State).

Signature

DAYCARE VERIFICATION FORM

To be completed by a DAYCARE, AFTERSCHOOL, or SUMMERCARE Provider

To be used by the Division of Child Support Services in legal actions.

To the Childcare Provider:

The legal custodian of the named child(ren) states that (s)he pays childcare costs for the child(ren) while (s)he works or attends classes for future employment. Under the Georgia Law these costs figure prominently in calculating the support that the child's other parent should pay. Please help us to determine a fair support award, by completing this form.

Thank you, DCSS Representative

Please list all the children of the above CUSTODIAN for whom you provide care:

Case Child(ren)	<u>Birthdate</u>	<u>Type Of Ser</u>	vices You Provid	<u>e</u>
,	DOB:	[_] Daycare	[_] Afterschool	[_] Summer Care
,	DOB:	[_] Daycare	[_] Afterschool	[_] Summer Care
,	DOB:	[_] Daycare	[_] Afterschool	[_] Summer Care
,	DOB:	[_] Daycare	[_] Afterschool	[_] Summer Care
,	DOB:	[_] Daycare	[_] Afterschool	[_] Summer Care
What is the COST\Type of care you provide for the	named child(ren):			
[_] Daily, such as for preschoolers		Weekly Cost: \$		_
[_] Afterschool and holidays		Weekly Cost: \$		_
[_] Summer Care		Weekly Cost: \$		_
[_] Irregularly How often:		<u>Average</u> Weekly	cost: \$	
Does the named Custodian pay the full amount of the o	cost? [_] Yes [_] No		party or agency pa	ys part or all of the childcare, please
[_] Daycare is provided through DFCS, in the amount o	f \$		stodian pays: \$	
[_] Another person pays (Relationship to child(ren):		Am	ount they pay: \$	
Is it your understanding that the Custodian is working o	r in classes during the period y	/ou provide care: [_]	Yes [_] No	
Where:				
Does the above cost include other children of this Cust	odian? If so, please name the	m.		
Your Name:	Title			
Name of your facility:	or [_]	Home Daycare		
Address				
Phone number:				

If possible, attach a printout of the receipts over the last 12 months

INFORMATION AFFIDAVIT

You may submit this form <u>by mail</u> with attached EVIDENCE, but you MUST show that a <u>Substantial</u> <u>Change</u> has occurred <u>since</u> the original Support Amount was set by court order or since the last review was conducted.

The following facts should be considered when	n determining if my child support	amount should go up,	down, or remain
the same:			

Were the parents of the case child(ren) divorced [_] Yes, County:, State:,	from one another? [_] No, [_] Never married Year: [_] Still married, not yet divorced
Please indicate the number of Documents you ha	we attached to PROVE the above statements:
	naking false statements and false swearing under Georgia test to the truthfulness of the information provided.
So sworn and affirmed,	
Your Signature:	SSNDate://
Notary Public Signature:	Commission Expiration Date:
//	

NOTARY SEAL:

STATEMENT OF MEDICAL NEED\COST

(Use to show SPECIAL MEDICAL CONDITIONS that have occurred since the last support amount was ordered)

THIS INFORMATION IS REQUIRED:				
Medical Insurance provided for the children : (CHECK all known s	ources of medical insurance for	these children)		
[_]NCP provides: [_]Medical; [_]Dental; [_]Vision; []Life; Insurance Co:		Does CP have card? [_]No [_]Yes		
[_]CP provides: [_]Medical; [_]Dental; [_]Vision; []Life; Insurance Co:		[_]Medicaid [_]Peach Care		
[_]YOUR Spouse provides: [_]Medical; [_]Dental; [_]Vision; []Life; Insurar	ice Co:	Insurance cost per pay period: \$		
Extraordinary Medical Expenses: [] Co-payments, Amounts:	; [] Deductibles, Amounts:			
Military Medical Benefits for the case child(ren), based on current, reserves, or retired status:				
Military Medical Benefits [_] ARE \ [_]ARE NOT available for the named child(re	 As provided by [_]NCP [_]CP 	[_] Your Spouse's military benefits		
If Spouse provides insurance; Spouse's Name: Sp	ouse's employer:	Work Phone:		

This form will help you to show special or unusual medical needs of yourself or child. Please attach copies of Doctors' Statements showing WHAT the conditions is, HOW long it is expected to continue, How much YOUR portion of the cost of treatment is after all insurance has been paid, etc.... The more documentation you provide, the more weight this will carry with the Judge.

COMPLETE A NEW SECTION FOR EACH MEDICAL PROBLEM, EVEN IF IT IS FOR THE SAME PERSON.

(Make additional copies of this form as needed)	Relationship to You:
Patient's Name:	
	o function normally:
What kind of continued treatment is included:	
Name all REGULAR monthly office visits, medication	ons, and treatments which this condition require
What is the TOTAL monthly cost: \$	How much of this cost is YOUR portion: \$
Name of primary Physician:	Doctor's #: ()
Patient's Name:	Relationship to You:
Medical Condition:	Date of (injury\first treatment):
How long is this expected to last:	
How does this condition affect the patient's ability to	o function normally:
What kind of continued treatment is included:	
Name all REGULAR monthly office visits, medication	ons, and treatments which this condition require
What is the TOTAL monthly cost: \$	How much of this cost is YOUR portion: \$
Name of primary Physician:	Doctor's #: ()
Signed:	, [] CP Date://
	AL EXPENSES, SHOW PORTION <u>NOT</u> COVERED BY INSURANCE.
ATTACH A DOCTOR'S STATEMEN	T DIAGNOSIS, PROGNOSIS, & LENGTH OF EXPECTED TREATMENT

STATEMENT OF EMPLOYMENT AND INCOME HISTORY

(Use to show how your income has changed since the last support amount was ordered)

Instructions:

A person who is seeking a review for possible recommendation of modification or objecting to an increase in support, must show that changes in income are not due to his\her own actions and are expected to last over a year. This form will help you to show the facts.

- 1. Attach copies of <u>Separation Notices</u>, <u>Doctors' Statements</u> (if you left due to an injury), etc... The more documentation you provide, the more weight this will carry with the Judge.
- 2. Complete addresses are mandatory.
- 3. PROOF is required, or a Less-than-36-Month Review will not be justified.

Employer:Address:	
Phone:() Job Title: Period of employment: From// to//	
Paid: \$ per [_]Hr [_]Wk [_]Biwkly [_]Yrly Total of all bonuses, commissions, per diem, etc; received Yrly:	
Describe actual job duties:	
Reason for job termination: [_] Quit [_] Fired [_] Laid Off [_]Other Details:	
Did you receive: [_] Unemployment [_] Disability [_] Settlement Amount: \$ From:/ to//	
Proof of Income for this job: [_] W2's, 1099's, Tax Returns; [_] pay stubs; [_] Other:	
Proof of why I left this job: [_] Separation Notice; [_] Doctor's or Medical Statements; [_] Other:	
Employer:Address:	
Phone:() Job Title: Period of employment: From/ to/	
Paid: \$ per [_]Hr [_]Wk [_]Biwkly [_]Yrly Total of all bonuses, commissions, per diem, etc; received Yrly: \$	
Describe actual job duties:	
Reason for job termination: [_] Quit [_] Fired [_] Laid Off [_]Other Details:	
Did you receive: [_] Unemployment [_] Disability [_] Settlement Amount: \$ From:/ to//	
Proof of Income for this job: [_] W2's, 1099's, Tax Returns; [_] pay stubs; [_] Other:	
Proof of why I left this job: [] Separation Notice; [] Doctor's or Medical Statements; [] Other:	
Employer:Address:	
Phone:() Job Title: Period of employment: From/ to/	_
Paid: \$ per [_]Hr [_]Wk [_]Biwkly [_]Yrly Total of all bonuses, commissions, per diem, etc; received Yrly: \$	
Describe actual job duties:	
Reason for job termination: [_] Quit [_] Fired [_] Laid Off [_]Other Details:	
 Did you receive: [_] Unemployment [_] Disability [_] Settlement Amount: \$ From:/ to/	
Proof of Income for this job: [_] W2's, 1099's, Tax Returns; [_] pay stubs; [_] Other:	
Proof of why I left this job: [] Separation Notice; [] Doctor's or Medical Statements; [] Other:	
Signed:, Date://	
Please indicate the number of Documents attached to PROVE the above statements:	