State of Georgia
Department of Human Services
Division of Child Support Services

Local Office Stamp

APPLICANT INSTRUCTIONS

Thank you for applying for child support services. To offer Same Day Services (SDS), please provide detailed information to help us assist in processing your application. If you receive TANF/Medicaid services, please call the DCSS Contact Center for further assistance (number listed below).

Applicant must provide at least one form of photo identification, for example:

- Valid driver's license;
- Any other international government, federal government, state government and local government-issued picture/photo ID including a Green Card or Visa;
- Valid Passport.

Applicants MUST submit the following with the application:

- Birth certificates for all children born **OUTSIDE** of Georgia;
- Paternity Affidavit;
- Proof of RSDI dependent benefits received;
- Signatures on all pages and notarize forms where required;
- Verification of school enrollment, status, grade level and anticipated graduation date if the child(ren) is 18 and is still a full-time high school student and the court order addresses child support beyond the age of 18, if applicable;
- A photocopy of all support orders that exist (Final Divorce Decree, Separation or Settlement Agreement, Child Support Order entered by any state or foreign country, Modification of Support Order, Contempt Order, Juvenile Court Order and/or Temporary Order). **Exception:** A certified copy of the most recent order setting the support obligation is required if the order must be registered for enforcement in another state or foreign jurisdiction, before DCSS can process a UIFSA action;

The following documents are *preferred* when applying for services:

- Proof of physical custody of a minor child or dependent child;
- Current income information (i.e. check stubs, W-2's, or Tax Statements for past 3 years with 1099s if self-employed and a completed financial affidavit);
- Birth Certificates for all children born in Georgia;
- Social Security cards for all children listed in the application (if available);
- Receipts/verification of medical, vision, dental, life insurance, deductibles and co-pays, if applicable;
- Extraordinary educational expense information for tuition, room & board, fees, books, if applicable; and
- Child rearing expenses for music/art lessons, travel, band, clubs, and athletics, if applicable.
- Authorization Agreement for Direct Deposit of Child Support Payments if direct deposit is being requested and a voided check or savings account deposit slip.

Note: Please call the DCSS Contact Center toll-free at 1-844-MYGADHS (1-844-694-2347 Toll Free) if:

- You speak another language other than English in your home and need assistance,
- You have a disability and need assistance or accommodations to visit our office; or
- You are deaf or hearing impaired and need the assistance.

If you are a TTY (text telephone) user you may contact our office through the Georgia Relay Service at 7-1-1

Note: If possible, please make copies of important information and your entire application before visiting our office to retain for your records.

Applicant Rights and Responsibilities

I understand and agree that:

Initial All:

_____ The Division of Child Support Services (DCSS) has the authority under federal and state law to take any legal action that is necessary to establish paternity and to establish, modify and/or enforce an obligation for child support including medical support. DCSS does not guarantee that efforts on my behalf will be successful as actions taken by DCSS may be subject to the discretion of the judge.

_____ If I should receive payments distributed to me in error (overpayments), I will be notified in writing to establish a Recoupment Repayment Installment Plan with DCSS. I understand that my failure to respond timely to the third and "**Final Notice**" from DCSS shall serve as my permission for DCSS to recoup payments from any future child support due to me and I will be subject to ***interception of my state income tax refund***.

_____ If the person I named as the father of my child(ren) is excluded through paternity testing, I will be responsible for reimbursing DCSS for the cost of the test.

_____ I must submit myself and/or the child (ren) to genetic testing, as it relates to establishing paternity, if needed. Genetic test results will not be provided without prior written authorization to release such information.

_____ My case and current/arrears accounts will not be eligible for closure until all debts owed to the state, including fees and TANF arrears, are paid in full. If I fail to pay any fees and/or debts owed by me to DCSS I will be subject to ***interception of my state income tax refund***.

_____ Overpayments of the support ordered amount will be applied first to the past due amounts and then may be held by DCSS for future payments.

_____ DCSS may use an attorney to establish, enforce and/or modify my child support order. There is no attorney-client relationship between me and the attorney, as the attorney represents the State. I understand that the attorney does not handle legal issues such as legitimation, custody or visitation; therefore, I must seek my own private attorney regarding these issues.

_____ DCSS has provided me with a HIPAA Notice of Privacy Practices. The notice includes an explanation of how medical information related to my application for services may be used by DCSS, as well as my right to have access to this medical information. I understand that DCSS will not share any information unless I provide a written authorization requesting information.

_____DCSS will not release any confidential, personal information to any third parties without my prior written authorization to release such information.

_____ DCSS does not discriminate on the basis of race, color, national origin, sex, age, religion, political beliefs or disability. Should I have concerns about my case, I may file a formal complaint with the local office manager that will result in an internal management review.

_____ When applying for services as a payee, I must have legal or physical custody of a minor child. In the event that the custody of the child changes, the ordered child support may be redirected to the new custodian.

_____ I must notify DCSS of any changes to my name, address, phone number(s) or any other information that is needed to properly manage and/or enforce my case, including but not limited to, notifying DCSS that I have applied for Temporary Assistance For Needy Families (TANF) benefits. I understand that failure to keep information up to date may affect DCSS ability to distribute payments in a timely manner.

_____ I must notify DCSS if I have an active child support case with any other state agency, private attorney or a private collection agency for the child (ren) listed on the application.

_____ A $25.00 non-refundable application fee is required when applying for services unless the child(ren) or I receive Temporary Assistance for Needy Families (TANF) or Family Medical Assistance (Medicaid). The fee *will* be required if only the child(ren) receive Medicaid or I re-apply for services after requesting case closure or if my case is closed by DCSS due to my non-cooperation.

_____ A $35 Annual Maintenance Fee will be charged to each case where an applicant has never received TANF and for whom the State has collected at least $550.00 of support.

_____ Child support payments must be sent to the Family Support Registry and that I should not accept direct payments from the Non-Custodial Parent (NCP). If I accept payments from the NCP DCSS may close my case for non-cooperation.

_____ Upon written notification from DCSS, my case may be closed if I fail to cooperate. Prior to case closure, I must repay any outstanding debts, including fees and overpayments that are owed at the time and repay any expenses incurred on my behalf. If my case is closed due to severe non-cooperation, I will not be able to reopen my case or re-apply for services for a minimum period of six (6) months from the date my case was last closed.

_____ If I request case closure during a legal proceeding to establish or enforce a support order and my case is eligible for closure, DCSS will not close my case until all legal actions have been completed and all fees/debts owed to the state are paid in full.

_____ Federal law authorizes DCSS to charge an individual who has applied for child support services and who has never or is no longer receiving TANF assistance a fee for the offset of state and federal taxes. In the event that an offset is received, an administrative fee of $12.00 per state offset and $25.00 per federal offset may be assessed to my case.

_____ I authorize DCSS to send correspondence electronically, including via email, text messages, and other methods. To ensure confidentiality of such correspondence, I understand that it is my responsibility to provide a secure and active email address and mobile phone number.

_____ I may obtain my case and payment information by calling the Contact Center at 1-844-MYGADHS (1-844-694-2347 Toll Free) or I may view my case information on the Customer Service Online website at https://services.georgia.gov/dhr/cspp/do/Logon.

I have received and read all program information describing available services, fees, as well as my rights and responsibilities. I have the right to ask questions before I submit my application. My signature on this document authorizes the Division of Child Support Services to provide necessary and appropriate services on my behalf. I certify that all of the information supplied by me in my Portal application is true and correct to the best of my knowledge and belief. 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.

_____ _____

Name of Applicant (Please Print Clearly) Signature of Applicant

_____ _____

Witness Date

Applicant's Email address is: (Please Print Clearly) _____

Application for Services

PLEASE CHECK ONE

I AM THE: Custodial parent [ ] Noncustodial parent [ ] Nonparent Custodian [ ] Alleged Father [ ]

TYPE OF SERVICE REQUESTED (check which applies)

All services available for support [ ]

TANF HISTORY (check all that apply):

I have never received TANF benefits [ ] I currently receive TANF benefits [ ] I currently receive Medicaid Only [ ]
Formerly on TANF [ ]: Received from _____ to _____

CUSTODIAL PARENT/NONPARENT CUSTODIAN INFORMATION

Name:

Last First Middle Maiden Name

Social Security Number:	Date of Birth:	Place of Birth:
Sex: Male [ ] Female [ ]	Have you ever had a child support case in another state? [ ] Yes [ ] No	

Check all that apply.

Race: [ ] AI-American Indian, Alaskan Native(N) [ ] FP–Filipino(F) [ ] OA–Other Asian(A) [ ] UN–Unknown(U)
[ ] AS-Asian Indian(I) [ ] GC–Guamian or Chamorro(G) [ ] OT–Other, Mixed or Multiple(M) [ ] VT–Vietnamese(V)
[ ] BL-Black or African American(B) [ ] JP–Japanese(J) [ ] PE–Persian(R) [ ] WH–White(W)
[ ] CH-Chinese(C) [ ] KO–Korean(K) [ ] PI–Other Pacific Islander(X)
[ ] EA-East Asian (E) [ ] NH–Native Hawaiian(P) [ ] SA–Samoan(S) [ ] Choose not to answer

Ethnicity: [ ] CB-Cuban(F) [ ] CH-Chicano/a(CH) [ ] MA-Mexican – American(W) [ ] ME-Mexican(M)
[ ] NH-Not Hispanic or Latino(N) [ ] OT-Other Latino / Hispanic [ ] PR-Puerto Rican(P) [ ] UN-Unknown(U)
[ ] Choose not to answer

Marital Status: Single [ ] Married [ ] Separated [ ] Divorced [ ] Divorced on: ___/___/___	If married, current spouse's name:_____ Date of Marriage: ___/___/___

Home Address:

Street Address City, County State, Zip

Mailing Address:

Street Address / P.O. Box City, State Zip

May be contacted at work? [ ] Yes [ ] No		E-Mail Address:
Work Phone:	Home Phone:	Cellular Phone:

Is the custodial parent/nonparent custodian in the military? [ ] Yes [ ] No If so, name the Military Branch: **[ ]** Retired Military

INSURANCE INFORMATION FOR CUSTODIAL PARENT

Do you currently have health insurance? [ ] Yes [ ] No	If yes, is the minor child you are applying for child support services covered in this Policy? [ ] Yes [ ] No
Insurance Co. Name:	Phone No.:
Policy No.:	Group#:

DOMESTIC VIOLENCE

Have you ever been a victim of domestic violence? [ ] **Yes** [ ] **No**
Has the child(ren) you are requesting services for ever been a victim any physical or emotional harm? [ ] **Yes** [ ] **No**
If yes to either or both of the above questions, describe your concerns and/or attach supporting documentation to support your claim on the application.
Under Georgia Law, O.C.G.A. §19-11-30 and §19-11-131, the DCSS will not release any information that would place you or your children at risk of physical or emotional harm. In such instances, a Family Violence Indicator will be activated on your child support case.
Your case will then be coded to ensure that no information is released to any other state or foreign jurisdiction that may place you or your child(ren) at risk.

CHILDREN FOR WHOM YOU NEED SERVICES

Race Codes: Enter the "Race Code" for each child in the appropriate box.

Code	Race	Code	Race	Code	Race	Code	Race
AI	American Indian, Alaska Native(N)	FP	Filipino(F)	OA	Other Asian(A)	UN	Unknown(U)
AS	Asian Indian(I)	GC	Guamian /Chamorro(G)	OT	Other, Mixed /Multiple(M)	VT	Vietnamese(V)
BL	Black or African American(B)	JP	Japanese(J)	PE	Persian(R)	WH	White(W)
CH	Chinese(C)	KO	Korean(K)	PI	Other Pacific Islander(X)		
EA	East Asian(E)	NH	Native Hawaiian(P)	SA	Samoan(S)	NA	Choose not to answer

Ethnicity Codes: Enter the" Ethnicity Code (Ethn)" for each child in the appropriate box.

Code	Ethnicity	Code	Ethnicity
CB	Cuban(F)	NH	Not Hispanic or Latino(N)
CH	Chicano/a(CH)	OT	Other Latino / Hispanic(O)
MA	Mexican – American(W)	PR	Puerto Rican(P)
ME	Mexican(M)	UN	Unknown(U)
NA	Choose not to answer		

Child's Name (Last, First, Middle)	SSN	Date of Birth	Place of Birth (City, State)	Sex M/F	Race Code	Ethn Code	Born Out of Wedlock Yes/No	Paternity Established by: Court Order/ Paternity Test? Date:

Your relationship to the child (ren): [ ] Biological Mother [ ] Biological Father [ ] Custodian [ ] Nonparent/Relative
[ ] Legal Guardian (proof of guardianship is required) [ ] Other:_____

PAYMENT INSTRUCTIONS FOR CUSTODIAL PARENT / CUSTODIAN

Unless a request is made for direct deposit a debit card will be provided for child support payments. If direct deposit is selected, a separate form and voided check / deposit slip are required.

ALLEGED FATHER / NONCUSTODIAL PARENT INFORMATION

Name:

Last First Middle Maiden Name

Aliases or nicknames:

Social Security Number: | Date of Birth or Age: | Place of Birth:

Sex: Male [ ] Female [ ]

Marital Status: Single [ ] Married [ ] Separated [ ]
Divorced [ ] Divorced on: ___/___/___

If married, current spouse's name:_____
Date of Marriage: ___/___/___

Eye color: | Hair color: | Weight: | Height:

Check all that apply.

Race:
[ ] AI-American Indian, Alaskan Native(N)
[ ] AS-Asian Indian(I)
[ ] BL-Black or African American(B)
[ ] CH-Chinese(C)
[ ] EA-East Asian (E)
[ ] FP–Filipino(F)
[ ] GC–Guamian or Chamorro(G)
[ ] JP–Japanese(J)
[ ] KO–Korean(K)
[ ] NH–Native Hawaiian(P)
[ ] OA–Other Asian(A)
[ ] OT–Other, Mixed or Multiple(M)
[ ] PE–Persian(R)
[ ] PI–Other Pacific Islander(X)
[ ] SA–Samoan(S)
[ ] UN–Unknown(U)
[ ] VT–Vietnamese(V)
[ ] WH–White(W)
[ ] Choose not to answer

Ethnicity: [ ] CB-Cuban(F) [ ] CH-Chicano/a(CH) [ ] MA-Mexican – American(W) [ ] ME-Mexican(M)
[ ] NH-Not Hispanic or Latino(N) [ ] OT-Other Latino / Hispanic [ ] PR-Puerto Rican(P) [ ] UN-Unknown(U)
[ ] Choose not to answer

Mailing Address: [ ] Owns this or other property

Street Address City, County State, Zip

Is home address [ ]Current or [ ]Last known | Phone Number(s):

Other Possible Address:

Street Address City, State, Zip

Driver's License #: State:

ALLEGED FATHER / NONCUSTODIAL PARENT EMPLOYMENT

[ ] Employed [ ]Unemployed [ ] Self-employed | Type of Business: | Usual Occupation:

Current or Last Known Employer: | Phone No.:

Dates of employment: ____/____/____ to ____/____/____

Supervisor: | Job title:

Address:

Street Address City County State Zip

Gross income: $ per | Paid: [ ]Weekly [ ]Bi-weekly [ ]Monthly [ ]Semi-monthly
Attach Pay stubs, if possible

INSURANCE INFORMATION FOR ALLEGEDFATHER / NONCUSTODIAL PARENT

Does "alleged" father/NCP currently have health insurance? [ ] Yes [ ] No | If yes, is the minor child you are applying for child support services covered in this Policy? [ ] Yes [ ] No

Insurance Co. Name: | Phone No.:

Policy No.:

Monthly Premium: $_____ | Portion Paid for Child: $_____

OTHER INCOME SOURCES /RESOURCES

Federal Benefits Received: [ ] Social Security [ ] Postal [ ]RR Retirement [ ]Civil Service [ ] Military [ ] VA [ ] Retirement[_] Receives SSI Receiving

Unemployment Benefits? [ ] Yes [ ] No

Receiving Pension Plan benefits? [ ] Yes [ ] No If so, from what company?

Any professional licenses? [ ] Yes [ ] No If so, what type?:

Is the noncustodial parent in the military? [ ] Yes [ ] No If so, name the Military Branch: **[ ]** Retired Military

INCARCERATION HISTORY

Has the noncustodial parent been: [ ] in Prison [ ] on Probation or has Probation history
If incarcerated please give dates ____/____/____ to ____/____/____
Institution's name: _____
Institution's address or city/state:_____
If on probation or has a probation history please give:
Probation history dates ____/____/____ to _____/____/_____
Probation period to end: ___/___/___
Probation / parole officer's name: _____
Probation / parole officer's name: _____

ALLEGED FATHER / NONCUSTODIAL PARENT FAMILY HISTORY

Mother: | Maiden Name: | Phone #: ( )

Date of Birth: | Place of Birth: | Deceased On:

Address:

Street Address City, State, Zip

Father: | Phone No.:

Date of Birth: | Place of Birth: | Deceased on:

Address:

Street Address City, State, Zip

Other known Relative:	Relationship:
Address:	
Street Address City, State, Zip	
Other contact address (friends, etc):	
Name Street Address City, State, Zip	
Other contact phone number:	

Complete this section ONLY if you are NOT the child(ren)'s Parent

I, _____ am the legal custodian of the child(ren) named above. I obtained legal custody for the child(ren) on ___/___/___ (proof of guardianship is required). Acceptable legal documents include, but are not limited to, Juvenile Court custody orders, Superior Court custody orders and Probate Court guardianship orders.
My relationship to the child(ren) is _____. The child(ren) came to live with me on (MM/DD/YY): ___/___/

Biological Mother (note if deceased):				
Name	Address	City, County, State, State, Zip	Date of Birth	SSN
Biological Father (note if deceased):				
Name	Address	City, County, State, State, Zip	Date of Birth	SSN

_____ _____

Signature **Date**

Under the penalty of perjury, I do hereby swear and affirm that the information I provided on the Application for Child Support Services is accurate and true to the best of my knowledge. I understand that knowingly making false statements and false swearing is punishable under Georgia law by a fine up to $1,000, by imprisonment between one and five years, or both. I do hereby attest to the truthfulness of the information provided.

_____ _____

Applicant Signature **Date**

For DCSS Office Use Only:

Application Requested Date **(required)**:___/___/___ Application Provided (date given in person or mailed) **(required)**:___/___/___ Application Provided by **(staff's first and last name required)**:_____

(**Note:** Federal regulations require an application be provided the same day to individuals who make in person requests or within 5 working days of a written or telephone request, see 45CFR §303.2(a)(2)).

Date returned to DCSS ___/___/___ Application Processed Date **(required)**:___/___/_____ Processed by (First & Last Name)_____$TARS No: _____ Application fee PAID (Y/N): [_]; If no, why not?_____

PERSONAL / FINANCIAL AFFIDAVIT

$TARS Case Number: _____
Non-Custodial Parent Name: _____
Custodial Parent Name: _____

CUSTODIAL PARENT [ ] NON CUSTODIAL PARENT [ ] NON PARENT CUSTODIAN [ ]

PERSONAL INFORMATION:
Your name: _____ DOB: _____ Social Security Number:_____

Other married names, nicknames, etc: _____
Home address:_____
Street Address City State County Zip

ADOPTION / FOSTER CARE:

[ ] Currently receive [ ] Never received [ ] Reunification / Foster Care Plan
How much monthly? $_____

YOUR EMPLOYMENT:

[ ] Employed [ ] Unemployed [ ] Self-employed Type of Business:_____

Employer: _____ Job Title:_____
Supervisor:_____ Work Phone No: _____

Employer address: _____
Street Address City State County Zip

Employed from ____/____/____ to ____/____/____ [ ] Union:_____ Local No:_____

GROSS Income: $_____ (Attach pay stubs) Pay Frequency: [ ] Weekly; [ ] Bi-weekly; [ ] Monthly; [ ] Semi-monthly

Do you have any Professional licenses: [ ] Yes If so, what type? _____ License #:_____

NAME OF BANK / CREDIT UNION:

_____ **Account Type [ ] Checking [ ] Savings Acct #:**_____

_____ **Account Type [ ] Checking [ ] Savings Acct #:**_____

YOUR TANF (WELFARE) HISTORY:
[ ] Never on TANF [ ] Currently on TANF [ ] Formerly on TANF [ ] History Unknown
[ ] Receives Medicaid Only; [ ] Receives Food Stamps only; TANF received from ___/___/___ to ___/___/___

PREVIOUS EMPLOYMENT (LAST 3 YRS):
Provide City, State & Employer Name. Complete addresses are not required.

Employer Name	City, State	Dates of Employment
Employer Name	City, State	Dates of Employment
Employer Name	City, State	Dates of Employment

EDUCATIONAL HISTORY:
Highest grade level in school you have completed: _____

Highest degree you have earned: [ ] None [ ] GED [ ] Technical College/AA [ ] College Degree or higher

Last School (High School, Trade, Colleges) attended:

Name	Street	City	State	Zip	Phone Number
Name	Street	City	State	Zip	Phone Number

PRE-EXISTING CHILD SUPPORT ORDERS BEING PAID FOR OTHER CHILDREN:

COURT NAME AND COURT CASE NUMBER	INITIAL DATE OF ORDER	NAMES AND BIRTHDATES OF CHILDREN	IS CHILD RECEIVING TANF?	AMOUNT BEING PAID PAYMENT RECORD REQUIRED
				$
				$
				$
				$

OTHER CHILDREN

NAME _____ DOB ___/___/___	NAME _____ DOB ___/___/___

YOUR FINANCIAL SUMMARY

Gross Income Source	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 [Refer to O.C.G.A. §19-6-15 (f)(1)(B) for details]	$	Child care (proof is required)	$
		Alimony Paid (proof is required)	$
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 (proof is required)	$
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, home)	$
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 (i.e., tuition, books, room & board) (proof is required)	$
Alimony & maintenance from persons not on this case	$		
Assets which are used for support of family	$	Child's extraordinary medical expenses (co-pays, deductibles) (proof is required)	$
Fringe Benefits (if significantly reduce living expenses)	$		
Any other income including Imputed Income: (Do not include means-tested public assistance, such as TANF or Food Stamps)	$	Special expenses for child rearing (i.e., camp, band, music, art, clubs) (proof is required)	$
		Other:	$
TOTAL MONTHLY GROSS INCOME:	$	**TOTAL MONTHLY EXPENSES:**	$

YOUR ASSETS: (Bank accts, bonds, whole life insurance-cash value CDs, Money Market Accts, property, stocks, vehicles, etc.)

Asset Description	Value	Asset Location / Branch
	$	
	$	
	$	

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:**

Paternity Affidavit

This form is REQUIRED for each child on this case, if any of the following situations apply:

- The child's parents were not married at the time of conception or birth and paternity has not been established;
- Paternity was established in Georgia (parents were married or signed a Paternity Acknowledgement Form) but is now being denied or contested;
- Paternity is in doubt for some other reason.

My Name Is _____ and I am the:

[_] MOTHER, applying for Child Support Services as [_] The Custodial Parent, [_] The Non-Custodial Parent;
[_] NON-Parent Custodian (CU) with custody of the child(ren) (Complete this form to the best of your knowledge);
[_] ALLEGED FATHER, who is applying for Child Support Services as [_] The Non-Custodial Parent, [_] The Custodial Parent.

Child's Information			
Child's Name as listed on the Birth Certificate			
Child's Last	Child's First	Child's Middle	Child's Date of Birth
Sex [ ] Male [ ] Female	Social Security Number	Race	Relationship to Applicant for Services
Child was conceived in: City		State	Country
Name of Hospital where child was born: _____			
City	State	Country	
Name of the child's father? _____		Is his name on the Birth Certificate? [ ] Yes	[ ] No
Information About the Relationship Between the Mother and Alleged Father			
Mother's Marital Status at child's birth: [ ]Single [ ]Married [ ]Separated [ ]Divorced on _____/____/_____ Husband's Name: _____			
I believe _____ is the father of my child(ren) because we had sexual contact. (Name of alleged father) County in which the child was conceived _____			
Has the mother ever named **anyone else** as the father of this child? [ ] Yes [ ] No [ ] Unsure If so, name: Address:			
Did the alleged father ever sign a Paternity Statement or Paternity Acknowledgment for this child? [ ] Yes [ ] No **If yes, when: ____/___/____** **What State: _____**			
Has the alleged father provided child support, necessities, or gifts for this child? In what way?			
Has paternity testing ever been done regarding this alleged father? [ ] Yes [ ] No If yes, attach a copy of the RESULTS			
Has paternity testing ever been done on any other man? [ ] Yes [ ] No If yes, attach a copy of the RESULTS			

Personally appeared before the undersigned officer, duly authorized to administer oaths, the undersigned who states under oath that the foregoing statements regarding paternity are true and correct. I understand that medical tests may be required to establish legal paternity for the above child(ren). My signature on this document authorizes the Division of Child Support Services to provide necessary and appropriate services on my behalf regarding genetic testing and legal actions to establish paternity for the child(ren).

I certify that all of the information supplied by me is true and correct to the best of my knowledge and belief. 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.

Printed Name: _____

Your Signature: _____ Date: _____

Notary Public Signature: _____ Commission Expiration Date: _____

NOTARY SEAL

DCSS Case Number: «FIELD52»

COURT ORDERS, SUPPORT ORDERS, AND ARREARAGE OWED

Note: Check each type of order. You MUST provide a certified copy of the order(s) to be enforced.

[ ] There is NO Court Order requiring either parent to pay support for the children of this case, because:		
[ ] I am currently married to the NCP (no divorce)	Marriage Date:	Separation Date:
[ ] I was never married to the NCP. (You MUST complete a Paternity Affidavit for each child of this NCP)		
[ ] The mother of the child(ren) was married when the child(ren) was/were born?	Marriage Date:	Separation Date:

[ ] DIVORCE DECREE [ ] DCSS SUPPORT ORDER [ ] LEGITIMATION ORDER [ ] CUSTODY ORDER				
Filed in	County, State of	on	[ ] NCP not ordered to pay child support.	
Support Ordered Amount: $	per	[ ] For each child	[ ] For All children	
There is an Arrearage (overdue) of $	as of	Complete the attached Arrearage Affidavit*		
[ ] CONTEMPT ORDER [ ] MODIFICATION ORDER [ ] JUVENILE ORDER				
Filed in	County, State of	on	[ ] NCP not ordered to pay child support.	
Support Ordered Amount: $	per	[ ] For each child	[ ] For All children	
There is an Arrearage (overdue) of $	as of	Complete the attached Arrearage Affidavit*		
[ ] URESA / UIFSA ORDER (support order from another state)		**Note: We must have certified copies**		
Filed in	County, State of	on	[ ] NCP not ordered to pay child support.	
Support Ordered Amount: $	per	[ ] For each child	[ ] For All children	
There is an Arrearage (overdue) of $	as of	Complete the attached Arrearage Affidavit*		
[ ] TEMPORARY PROTECTIVE ORDER		**Note: We must have certified copies**		
Filed in	County, State of	on	[ ] NCP not ordered to pay child support.	
Support Ordered Amount: $	per	[ ] For each child	[ ] For All children	
There is an Arrearage (overdue) of $	as of	Complete the attached Arrearage Affidavit*		

***Notes: Cases with court orders will require an Affidavit of Arrears to be completed.**
Any support **NOT** paid through Georgia DCSS will require a **certified** payment history.

PRIVATE CHILD SUPPORT CASE HISTORY	
Have you ever had an active child support case with any other state agency, private attorney or a private collection agency for the child(ren) listed on this application?	[ ] Yes If so, list below:
	Where:
	When:

ARREARAGE AFFIDAVIT: Please show the total amount of support **owed and received** in each month. Receipts, canceled checks, payment records, etc. may be requested to prove the information in this affidavit.

Year	Amount		Year	Amount		Year	Amount	
	Due	Paid		Due	Paid		Due	Paid
Jan	$	$	Jan	$	$	Jan	$	$
Feb	$	$	Feb	$	$	Feb	$	$
Mar	$	$	Mar	$	$	Mar	$	$
Apr	$	$	Apr	$	$	Apr	$	$
May	$	$	May	$	$	May	$	$
Jun	$	$	Jun	$	$	Jun	$	$
Jul	$	$	Jul	$	$	Jul	$	$
Aug	$	$	Aug	$	$	Aug	$	$
Sep	$	$	Sep	$	$	Sep	$	$
Oct	$	$	Oct	$	$	Oct	$	$
Nov	$	$	Nov	$	$	Nov	$	$
Dec	$	$	Dec	$	$	Dec	$	$
YTD Total	$	$	YTD Total	$	$	YTD Total	$	$

Year	Amount		Year	Amount		Year	Amount	
	Due	Paid		Due	Paid		Due	Paid
Jan	$	$	Jan	$	$	Jan	$	$
Feb	$	$	Feb	$	$	Feb	$	$
Mar	$	$	Mar	$	$	Mar	$	$
Apr	$	$	Apr	$	$	Apr	$	$
May	$	$	May	$	$	May	$	$
Jun	$	$	Jun	$	$	Jun	$	$
Jul	$	$	Jul	$	$	Jul	$	$
Aug	$	$	Aug	$	$	Aug	$	$
Sep	$	$	Sep	$	$	Sep	$	$
Oct	$	$	Oct	$	$	Oct	$	$
Nov	$	$	Nov	$	$	Nov	$	$
Dec	$	$	Dec	$	$	Dec	$	$
YTD Total	$	$	YTD Total	$	$	YTD Total	$	$

Total Due:$_____ **Minus** Total Paid:$_____ = Balance Due: $_____ as of _____.

I certify that all of the information supplied by me is true and correct to the best of my knowledge and belief. 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,

My Signature:_____ Date: _____

Notary Public Signature:_____ Commission Expiration Date: _____

NOTARY SEAL:

Brian P. Kemp
Governor

Robyn A. Crittenden
Commissioner

Georgia Department of Human Services

Aging Services | Child Support Services | Family & Children Services

HIPAA Notice of Privacy Practices
Georgia Department of Human Services

Date: *April 8, 2016*

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

The Department of Human Services (DHS) is an agency of the Executive Branch of Georgia government charged with the administration of numerous federal programs responsible for the storage, use and maintenance of medical and other confidential information. Federal and state laws establish strict requirements for these programs regarding the use and disclosure of confidential and protected information. DHS is required to comply with those laws as noted throughout this Notice.

OBLIGATIONS OF THE DEPARTMENT OF HUMAN SERVICES:

DHS is required by law to:

- Maintain the privacy of protected health information;
- Give you this notice of our legal duties and privacy practices regarding health information about you; and
- Follow the terms of our notice currently in effect.

HOW DHS MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways DHS may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, DHS will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to the HIPAA Privacy Officer at the contact information above.

For Treatment. DHS may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, DHS may disclose Health Information to doctors, nurses, technicians, or other personnel who are involved in your medical care and need the information to provide you with medical care.

For Payment. DHS may use and disclose Health Information so that DHS or others may bill and receive payment related to your care, an insurance company, or a third party for the treatment and services you received. For example, DHS may provide your health plan information so that treatment may be paid for.

For Health Care Operations. DHS may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that quality care is received and to operate, manage, and administer the functions of the agency. For example, DHS may use and disclose information to make sure the medical care you receive is of the highest quality. DHS also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. DHS may use and disclose Health Information to contact you to remind you of an appointment with a physician. DHS also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, DHS may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a

close friend. DHS also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, DHS may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before DHS uses or discloses Health Information for research, the project will go through a special approval process. Even without special approval, DHS may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. DHS will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. DHS may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. DHS may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, DHS may utilize the services of a separate entity to perform billing services. All DHS business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, DHS may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, DHS may release Health Information as required by military command authorities. DHS also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. DHS may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. DHS may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if it is believed a patient has been the victim of abuse, neglect or domestic violence. DHS will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. DHS may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. DHS may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, DHS may disclose Health Information in response to a court or administrative order. DHS also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. DHS may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or

locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. DHS may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. DHS also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. DHS may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. DHS may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, DHS may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE DHS TO PROVIDE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, DHS may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, DHS may disclose such information as necessary if it is determined that it is in your best interest based on the professional judgment of DHS.

Disaster Relief. DHS may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. DHS will provide you with an opportunity to agree or object to such a disclosure whenever it is practical to do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to DHS will be made only with your written authorization. If you do provide DHS an authorization, you may revoke it at any time by submitting a written revocation to the above-referenced Privacy Officer. Upon receipt, DHS will no longer disclose Protected Health Information under the authorization. However, disclosures made in reliance upon your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information DHS has about you:
Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the above referenced HIPAA Privacy Officer. DHS has up to 30 days to make your Protected Health Information available to you and DHS may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. DHS may not charge you a fee if you need the information for a claim for benefits

under the Social Security Act or any other state of federal needs-based benefit program. DHS may deny your request in certain limited circumstances. If DHS does deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and DHS will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. DHS will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request, your record will be provided in either our standard electronic format. If you do not want this form or format, a readable hard copy form will be provided. DHS may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information DHS has is incorrect or incomplete, you may request DHS to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the above-referenced HIPAA Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures DHS made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the above-referenced HIPAA Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information DHS uses or disclosed for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information DHS discloses to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that DHS not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the above-referenced HIPAA Privacy Officer. DHS is not required to agree to your request unless you are requesting DHS restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid “out-of-pocket” in full. If DHS agrees, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that DHS communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that DHS only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the above-referenced HIPAA Privacy Officer. Your request must specify how or where you wish to be contacted. DHS will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may request a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact the above-referenced HIPAA Privacy Officer.

CHANGES TO THIS NOTICE:

DHS reserves the right to change this notice and make the new notice apply to Health Information already obtained as well as any information received in the future. DHS will post a copy of the current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you have any questions about this notice, please contact:

Georgia Department of Human Services
HIPAA Privacy Officer
2 Peachtree Street, NW Suite 29-210
Atlanta GA 30303-3142
HIPAADHS@dhs.ga.gov

If you believe your privacy rights have been violated, you may file a complaint, in writing, by contacting the above-referenced HIPAA Privacy Officer. **You will not be penalized for filing a complaint**.
You may also file with the Secretary of the Department of Health and Human Services. For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's web site, www.acog.org, or call (202) 863-2584.

_____

I have read, understand, and acknowledge receipt of the DHS HIPAA Notice of Privacy Practices.

_____ _____

Signature Date

_____

Print Name

Notice to applicant: *Please submit signed HIPAA notice with all other application material to your nearest DCSS office. It is not necessary to mail the HIPAA notice separately unless notified by a DCSS representative.*

GENERAL TESTIMONY

(Instructions should be provided to the petitioner as part of the form.)

THIS FORM CONTAINS SENSITIVE INFORMATION – DO NOT FILE THIS FORM IN A PUBLIC ACCESS FILE

The information on this form may be filed with the petition or pleading and may be disclosed to the parties in the case unless accompanied by a nondisclosure finding/affidavit.

If you are not the intended recipient, you are hereby notified that any use, disclosure, distribution, or copying of this form or its contents is strictly prohibited.

Personal Information Form for UIFSA § 311 must be attached.

File Stamp

Petitioner: Legal Name (first, middle, last, suffix)

[ ] **Obligee** [ ] **Obligor**

Tribal Affiliation (if applicable)

IV-D Case: [ ] TANF
[ ] IV-E Foster Care
[ ] Medicaid Only
[ ] Former Assistance
[ ] Never Assistance

Respondent: Legal Name (first, middle, last, suffix)

Non-IV-D Case: [ ]

[ ] **Obligee** [ ] **Obligor**

Tribal Affiliation (if applicable)

Responding IV-D Case Identifier: _____

Responding Tribunal Number: _____

NOTE:

[ ] Nondisclosure Finding/Affidavit attached

[ ] This form sent through EDE

Initiating IV-D Case Identifier: _____

Initiating Tribunal Number: _____

I, _____ , declare under penalty of perjury:

Legal Name (first, middle, last, suffix)

I. Personal Information About Obligee: (Obligee caretaker complete section I.E only) [ ] See section IX

A. Obligee parent information

1.	Legal name (first, middle, last, suffix):
2.	Gender: [ ] Male [ ] Female [ ] Other
3.	a. Occupation, trade, or profession:
	b. Highest level of education attained:
4.	Current tax filing status: [ ] Single [ ] Head of household [ ] Married filing jointly [ ] Married filing separately [ ] Qualifying widow/widower with dependent children [ ] Unknown

B. Physical description of the obligee parent: (Attach a recent photo if available.)

1.	Race:	2.	Height:	3.	Weight:	4.	Hair color:
5.	Eye color:						

C. Is the obligee parent financially responsible for dependent children other than those of this action (listed in section IV)?

[ ] Yes [ ] No [ ] Unknown (If yes, provide information below if known.)

1.	a. Legal name (first, middle, last, suffix):	b. Year of birth:
	c. Relationship:	d. Living with:
2.	a. Legal name (first, middle, last, suffix):	b. Year of birth:
	c. Relationship:	d. Living with:

GENERAL TESTIMONY, PAGE 2

I. Personal Information About Obligee (Continued):

3.

a. Legal name (first, middle, last, suffix):	b. Year of birth:
c. Relationship:	d. Living with:

D. Does the obligee parent have an order to pay support for any child listed in C above? [ ] Yes [ ] No [ ] Unknown

(If yes, fill out information below, if known, and attach a copy of the order and payment record/proof of payment, if available.)

1.

a. Child(ren) name(s):	
b. Amount:	c. Frequency:
d. State and county/tribe/country:	e. Tribunal number:

2.

a. Child(ren) name(s):	
b. Amount:	c. Frequency:
d. State and county/tribe/country:	e. Tribunal number:

3.

a. Child(ren) name(s):	
b. Amount:	c. Frequency:
d. State and county/tribe/country:	e. Tribunal number:

E. Obligee Caretaker information: (Provide any relevant non-party parent information, including financial information, in section IX.)

1. Caretaker legal name (first, middle, last, suffix):
2. Caretaker relationship to child is: _____ [ ] Has legal custody/guardianship of child
3. Date child(ren) began residing with caretaker:

II. Personal Information About Obligor:

[ ] See section IX

A. Obligor information:

1.	Legal name (first, middle, last, suffix):
2.	Gender: [ ] Male [ ] Female [ ] Other
3.	a. Occupation, trade or profession:
	b. Highest level of education attained:
4.	Current tax filing status: [ ] Single [ ] Head of household [ ] Married filing jointly [ ] Married filing separately [ ] Qualifying widow/widower with dependent children [ ] Unknown

B. Physical description of the obligor: (Attach a recent photo if available.)

1. Race:	2. Height:	3. Weight:	4. Hair color:
5. Eye color:			

C. Is the obligor financially responsible for dependent children other than those of this action (listed in section IV)?

[ ] Yes [ ] No [ ] Unknown (If yes, provide information below if known.)

1.

a. Legal name (first, middle, last, suffix):	b. Year of birth:
c. Relationship:	d. Living with:

2.

a. Legal name (first, middle, last, suffix):	b. Year of birth:
c. Relationship:	d. Living with:

II. Personal Information About Obligor (Continued):

3.	a. Legal name (first, middle, last, suffix):	b. Year of birth:
	c. Relationship:	d. Living with:

D. Does the obligor have an order to pay support for any child listed in C above? [ ] Yes [ ] No [ ] Unknown

(If yes, fill out information below, if known, and attach a copy of the order and payment record/proof of payment, if available.)

1.	a. Child(ren) name(s):	
	b. Amount: $	c. Frequency:
	d. State and county/tribe/country:	e. Tribunal number:

2.	a. Child(ren) name(s):	
	b. Amount: $	c. Frequency:
	d. State and county/tribe/country:	e. Tribunal number:

3.	a. Child(ren) name(s):	
	b. Amount: $	c. Frequency:
	d. State and county/tribe/country:	e. Tribunal number

III. Legal Relationship of Parents of Children Listed in Section IV:

[ ] See section IX

A. [ ] Never married to each other

B. [ ] Married on _____ (Date) in _____ (State and county/tribe/country)

C. [ ] Married by common law for the period _____ (Dates) in _____ (State and county/tribe/country)

D. [ ] Legally separated on _____ (Date) in _____ (State and county/tribe/country)

E. [ ] Divorce pending in _____ (State and county/tribe/country)

F. [ ] Divorced on _____ (Date) in _____ (State and county/tribe/country)

G. [ ] Other _____

IV. Dependent Child(ren) in This Action:

[ ] See section IX

A.	1. Legal name (first, middle, last, suffix):		2. Parentage established? [ ] Yes [ ] No
	3. Child care expense per month $ _____	4. Support order established? [ ] Yes [ ] No	5. Living with petitioner? [ ] Yes [ ] No
	6. Does the child receive benefits from Social Security, VA, etc.? [ ] Yes [ ] No (If yes, complete the information below.) _____ (Benefit type(s)) $_____ per month Based on claim of _____ (Name) Relationship to child: _____		
	7. Tribal Affiliation [ ] Yes [ ] No (If yes, basis of tribal affiliation: _____)		

IV. Dependent Child(ren) in This Action (Continued):

B.

1. Legal name (first, middle, last, suffix):		2. Parentage established? [ ] Yes [ ] No
3. Child care expense per month $ _____	4. Support order established? [ ] Yes [ ] No	5. Living with petitioner? [ ] Yes [ ] No
6. Does the child receive benefits from Social Security, VA, etc.? [ ] Yes [ ] No (If yes, complete the information below.) _____ $_____ per month (Benefit type(s)) Based on claim of _____ Relationship to child: _____ (Name)		
7. Tribal Affiliation [ ] Yes [ ] No (If yes, basis of tribal affiliation: _____)		

C.

1. Legal name (first, middle, last, suffix):		2. Parentage established? [ ] Yes [ ] No
3. Child care expense per month $ _____	4. Support order established? [ ] Yes [ ] No	5. Living with petitioner? [ ] Yes [ ] No
6. Does the child receive benefits from Social Security, VA, etc.? [ ] Yes [ ] No (If yes, complete the information below.) _____ $_____ per month (Benefit type(s)) Based on claim of _____ Relationship to child: _____ (Name)		
7. Tribal Affiliation [ ] Yes [ ] No (If yes, basis of tribal affiliation: _____)		

V. Health Care Coverage: [ ] See section IX

A. **Health Care Coverage for Child(ren):** For each child listed in section IV, complete the information below.

1. a. Child's name: _____
Does this child have health care coverage? [ ] Yes [ ] No [ ] Unknown (If no or unknown, skip to 1.e.)

b. Health care coverage is provided by (check all that apply):
[ ] Medicaid (Skip to 1.e.) [ ] CHIP (Skip to 1.e.) [ ] TRICARE (Skip to 1.e.)
[ ] Indian Health Service (Skip to 1.e.)
[ ] Petitioner through an individual policy (Continue to 1.c below.)
[ ] Petitioner through his/her employer (Continue to 1.c below.)
[ ] Respondent through an individual policy (Continue to 1.c below.)
[ ] Respondent through his/her employer (Continue to 1.c below.)
[ ] Other person: _____ Relationship to child: _____ (Complete 1.c below.)

c. Health care coverage provider name: _____
Address:
Policy ID number: _____ Group number: _____

d. Is this a child only policy? [ ] Yes [ ] No (If yes, what is the monthly premium for this child only? $_____)

e. Who claims a dependency exemption for the child for federal tax purposes? [ ] Obligee [ ] Obligor [ ] Other
If other, identify the person: _____ Relationship to child: _____
(Attach a copy of any order addressing the dependency exemption.)

f. Does the individual entitled to claim the dependency exemption change from year to year?
[ ] Yes [ ] No (If yes, explain.)_____

V. Health Care Coverage (Continued):

2. a. Child's name: _____

Does this child have health care coverage? [ ] Yes [ ] No [ ] Unknown (If no or unknown, skip to 2.e.)

If yes, is all the information the same as Child 1? [ ] Yes (Skip to 2.e.) [ ] No (Continue with 2.b.)

b. Health care coverage is provided by (check all that apply):

[ ] Medicaid (Skip to 2.e.) [ ] CHIP (Skip to 2.e.) [ ] TRICARE (Skip to 2.e.)

[ ] Indian Health Service (Skip to 2.e)

[ ] Petitioner through an individual policy (Continue to 2.c below.)

[ ] Petitioner through his/her employer (Continue to 2.c below.)

[ ] Respondent through an individual policy (Continue to 2.c below.)

[ ] Respondent through his/her employer (Continue to 2.c below.)

[ ] Other person:

_____ Relationship to child: _____ (Complete 2.c below.)

c. Health care coverage provider name: _____

Address:

Policy ID number: _____ | Group number: _____

d. Is this a child only policy? [ ] Yes [ ] No (If yes, what is the monthly premium for this child only? $_____)

e. Who claims a dependency exemption for the child for federal tax purposes? [ ] Obligee [ ] Obligor [ ] Other

If other, identify the person: _____ Relationship to child: _____

(Attach a copy of any order addressing the dependency exemption.)

f. Does the individual entitled to claim the dependency exemption change from year to year?

[ ] Yes [ ] No (If yes, explain in section IX.)

3. a. Child's name: _____

Does this child have health care coverage? [ ] Yes [ ] No [ ] Unknown (If no or unknown, skip to 3.e.)

If yes, is all the information the same as Child 1? [ ] Yes (Skip to 3.e.) [ ] No (Continue with 3.b.)

b. Health care coverage is provided by (check all that apply):

[ ] Medicaid (Skip to 3.e.) [ ] CHIP (Skip to 3.e.) [ ] TRICARE (Skip to 3.e.)

[ ] Indian Health Service (Skip to 3.e)

[ ] Petitioner through an individual policy (Continue to 3.c below.)

[ ] Petitioner through his/her employer (Continue to 3.c below.)

[ ] Respondent through an individual policy (Continue to 3.c below.)

[ ] Respondent through his/her employer (Continue to 3.c below.)

[ ] Other person: _____ Relationship to child: _____ (Complete 3.c. below.)

c. Health care coverage provider name: _____

Address:

Policy ID number: _____ | Group number: _____

d. Is this a child only policy? [ ] Yes [ ] No (If yes, what is the monthly premium for this child only? $_____)

e. Who claims a dependency exemption for the child for federal tax purposes? [ ] Obligee [ ] Obligor [ ] Other

If other, identify the person: _____ Relationship to child: _____

(Attach a copy of any order addressing the dependency exemption.)

f. Does the individual entitled to claim the dependency exemption change from year to year?

[ ] Yes [ ] No (If yes, explain in section IX.)

V. Health Care Coverage (Continued):

B. **Health Care Coverage for Petitioner**: Does the petitioner have health care coverage? [ ] Yes [ ] No (If no, skip to B.4.)

1. Petitioner's health care coverage is provided by: [ ] Medicaid (Skip to B.4.) [ ] TRICARE (Skip to C.)
   [ ] Indian Health Service (Skip to C.)
   [ ] Self through his/her employer (Continue to B.2 below.)
   [ ] Self through an individual policy (Continue to B.2 below.)
   [ ] Other person: _____ Relationship to petitioner: _____ (Complete B.2 below.)
2. Health care coverage provider name: _____
   Address:
   Policy ID number: _____ Group number: _____
   Monthly premium $_____ Portion for the child(ren) listed in section IV: $_____
3. Other than children of this action listed in section IV, are other adults and/or child(ren) included in this plan? [ ] Yes [ ] No
   (If yes, provide information below.)
   Total number of adults: _____ Total number of children: _____
4. If the petitioner does not have health care coverage or the coverage is through Medicaid, is employer-sponsored coverage available for:
   a. Self [ ] Yes [ ] No
   b. Child(ren) listed in section IV [ ] Yes [ ] No (If no, skip to C.)
5. Based on the residence of the child(ren), is the petitioner's employer-sponsored coverage accessible to the child(ren) in section IV? [ ] Yes [ ] No [ ] Unknown (If no, skip to C.)
6. How much would the premiums be for an insurance plan offered by the petitioner's employer?
   a. For self: $_____ per _____ (weekly, bi-weekly, semi-monthly, monthly, quarterly, yearly)
   b. To add child(ren) in section IV: $_____ per _____ (weekly, bi-weekly, semi-monthly, monthly, quarterly, yearly)

C. **Health Care Coverage for Respondent:** Does the respondent have health care coverage? [ ] Yes [ ] No (If no, skip to C.4.)
[ ] Unknown (If unknown, skip to D.)

1. Respondent's health care coverage is provided by: [ ] Medicaid (Skip to C.4.) [ ] TRICARE (Skip to D.)
   [ ] Indian Health Service (Skip to D.) [ ] Unknown (Skip to D.)
   [ ] Self through his/her employer (Continue to C.2 below.)
   [ ] Self through an individual policy (Continue to C.2 below.)
   [ ] Other person: _____ Relationship to respondent: _____ (Complete C.2 below.)
2. Health care coverage provider name: _____
   Address:
   Policy ID number: Group number:
   Monthly premium $_____ Portion for the child(ren) in section IV: $_____
3. Other than children listed in section IV, are other adults and/or child(ren) included in this plan? [ ] Yes [ ] No
   (If yes, provide information below.)
   Total number of adults: _____ Total number of children: _____
4. If the respondent does not have health care coverage or the coverage is through Medicaid, is employer-sponsored coverage available for:
   a. Self [ ] Yes [ ] No [ ] Unknown (If no or unknown, skip to question D.)
   b. Children listed in section IV [ ] Yes [ ] No [ ] Unknown (If no or unknown, skip to question D.)
5. Based on the residence of the child(ren), is the respondent's employer-sponsored coverage accessible to the child(ren) in section IV? [ ] Yes [ ] No [ ] Unknown (If no, skip to question D.)

V. Health Care Coverage (Continued):

6. How much would the premiums be for an insurance plan offered by the respondent's employer?
   a. For self: $_____ per _____ (weekly, bi-weekly, semi-monthly, monthly, quarterly, yearly)
   b. To add child(ren) in section IV: $_____ per _____ (weekly, bi-weekly, semi-monthly, monthly, quarterly, yearly)

D. Do any of the children listed in section IV have special needs or extraordinary medical expenses not covered by insurance? [ ] Yes [ ] No [ ] Unknown (If yes, provide additional information about the child(ren) involved, the type of needs/medical expenses, and the related costs in section IX.)

E. Is the petitioner asking to be reimbursed for medical expenses paid? [ ] Yes [ ] No (If yes, provide information below.)
Balance: $ as of _____ (date) (Provide date, type of expense, and cost in section IX.)
_____

F. Is the petitioner asking to be compensated for ongoing medical expenses? [ ] Yes [ ] No (If yes, provide information below.)
Type of expense: _____ Amount: $ _____ per _____ (frequency)
(Provide additional information about the child(ren) involved, the need for ongoing expenses, and the expenses in section IX.)

VI. Additional Information for Child Support Calculation:

[ ] See section IX

A. **Establishment** (If no child support order exists, complete the following section.)**:**

1. Does a custody/parenting time order exist? [ ] Yes [ ] No (If yes, complete the information below and attach a copy of the order.)
   Issuing tribunal number: _____ Date of order: _____
2. If an order does not exist, is there a written custody/parenting time agreement? [ ] Yes [ ] No (If yes, attach a copy.)
3. In the past 12 months or since separation (whichever is shorter), how many overnights has the child(ren) stayed with obligee _____ obligor _____?
4. Is child support sought for a period of time prior to the date of the petition for support (Uniform Support Petition)?
   [ ] Yes [ ] No (If yes, complete the following questions and section VIII for the period of time.)

a.	Support is sought from the following date: _____					
b.	During the period of time for which retroactive support is being sought, did the child(ren) reside with the obligor, other than the time specified under an existing custody/parenting time order? [ ] Yes [ ] No (If yes, describe.) _____					
c.	During the period of time for which retroactive support is being sought, did the obligor make direct payments to the obligee? [ ] Yes [ ] No (If yes, attach an affidavit of payments.)					
d.	Was public assistance paid for any of the children listed in section IV?					
	[ ] Yes [ ] No (If yes, check the appropriate box and provide the period of benefit and the state.)					
	[ ] TANF	First month	/ year	To Last month	/ year	By: State
	[ ] Medicaid	First month	/ year	To Last month	/ year	By: State
	[ ] Foster Care	First month	/ year	To Last month	/ year	By: State

VI. Additional Information for Child Support Calculation (Continued):

B. **Modification** (If a child support order exists that the petitioner seeks to modify, complete the following section.):

1. Indicate the basis for the modification petition (check all that apply):
   a. The earnings of the obligor have:
      [ ] substantially increased
      [ ] substantially decreased
   b. The earnings of the obligee have:
      [ ] substantially increased
      [ ] substantially decreased
   c. The needs of the child(ren) have:
      [ ] substantially increased
      [ ] substantially decreased
   d. [ ] The current support order was most recently established or modified at least 3 years ago or such lesser time as permitted by the laws of the responding jurisdiction.
   e. [ ] Other; explain: _____
2. Does a custody/parenting time order exist? [ ] Yes [ ] No (If yes, attach a copy of the order.)
   Issuing tribunal number_____ Date of order _____
3. If a custody/parenting time order does not exist, is there a written custody/parenting time agreement? [ ] Yes [ ] No (If yes, attach a copy of the agreement.)
4. In the past 12 months or since separation (whichever is shorter), how many overnights has the child(ren) stayed with the obligee _____ obligor _____?

VII. Support Order and Payment:

[ ] See section IX

A. Is there an order for divorce or legal separation involving the children in this action?
[ ] Yes [ ] No (If yes, provide a copy of the order.)

B. Does a current support order exist? [ ] Yes [ ] No (If yes, attach obligor's support payment history.)

C. Does the support order require the obligor to pay amounts to anyone other than to the State Disbursement Unit (SDU) (e.g., directly to the obligee, child care provider, or health care provider)?
[ ] Yes [ ] No (If yes, complete D.)

D. Has the obligor made any direct payments under the order noted in C?
[ ] Yes [ ] No (If yes, attach an affidavit of payments.)

E. If a support order does not exist, has the obligor made any voluntary support payments?
[ ] Yes [ ] No (If yes, attach an affidavit of payments.)

VIII. Financial Information:

[ ] See section IX

Information required varies based on responding jurisdiction's support guidelines. Petitioner includes an obligee caretaker with legal custody of the child(ren).
.

Monthly income from all sources:

1. Is the petitioner employed? [ ] Yes; occupation: _____ [ ] No; income source: _____

VIII. Financial Information (Continued):

Monthly income from all sources (Continued):

		Petitioner
2.	Gross monthly income amounts:	
	a) Public Assistance	
	i) Supplemental Security Income (SSI)	$
	ii) TANF	$
	iii) Other	$
	b) Base pay salary, wages	$
	c) Overtime, commission, tips, bonuses, part time	$
	d) Unemployment compensation	$
	e) Worker's compensation	$
	f) Social Security Disability (not SSI)	$
	g) Social Security Retirement	$
	h) Dividends and interest	$
	i) Trust/annuity income	$
	j) Pensions, retirement	$
	k) Child support	$
	l) Spousal support/alimony	$
	m) Income producing assets	$
	n) All other sources (specify)	$
3.	Deductions from gross pay:	
	a) Federal income tax	$
	b) State income tax	$
	c) Local tax	$
	d) FICA	$
4.	Other deductions:	
	a) Mandatory retirement	$
	b) Nonmandatory retirement	$
	c) Medical insurance	$
	d) Union dues	$
	e) Other (specify)	$
5.	Gross income prior year:	$

IX. Other Pertinent Information:

[ ] Continued on attached sheet(s), incorporated by reference.

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X. Attached and Incorporated by Reference:

[ ] Required number of copies of all support orders for the case
[ ] Certified child support payment records
[ ] Arrears balance and/or accrued Interest (affidavit of arrears)
[ ] Payment history
[ ] Copies of three most recent pay stubs from current employer(s)
[ ] Copies of unreimbursed medical bills for the child(ren) in this action
[ ] Copy of most recent federal tax return
[ ] Declaration in Support of Establishing Parentage for each child whose parentage is at issue
[ ] Copy of child(ren)'s birth certificate(s)/record(s)
[ ] Acknowledgment of parentage
[ ] Documentation of legal custody/guardianship of child(ren)
[ ] Documentation of child care expenses
[ ] Documentation of ongoing medical expenses for the child(ren) in this action
[ ] Documentation in support of request for modification
[ ] Copy of order for divorce or legal separation involving the child(ren) in this action
[ ] Other: _____

[ ] Additional attached document(s), incorporated by reference.

XI. Declaration:

Under penalty of perjury, all information and facts stated in this General Testimony are true to the best of my knowledge and belief.

Date	Petitioner (Name)	Signature
Date	Name/Title, Agency or Tribunal Representative	Signature

Encryption Requirements:

When communicating this form through electronic transmission, precautions must be taken to ensure the security of the data. Child support agencies are encouraged to use the electronic applications provided by the federal Office of Child Support Enforcement. Other electronic means, such as encrypted attachments to e-mails may be used if the encryption method is compliant with Federal Information Processing Standard (FIPS) Publication 140-2 (FIPS PUB 140-2).

DIVISION OF CHILD SUPPORT SERVICES

Direct Deposit Authorization Form (*For use with online applications only*)

To have child support sent directly to your checking or savings account, please read, complete and print this form. Include a voided check or savings account deposit slip with your form. Mail both the voided check or savings account deposit slip and this form to your local Child Support Services office.

Section 1: AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT OF CHILD SUPPORT PAYMENTS

I authorize the Division of Child Support Services (DCSS) to deposit my child support payments directly into my checking account or savings account as specified below. **DCSS is also authorized to adjust any over/under deposit it has made to my checking account or savings account**. I understand the deposits/adjustments will be made electronically by ACH transactions and I must allow the Federal Reserve two workdays from the disbursement date to have the funds available to my financial institution. I also understand the following: It is my responsibility to provide correct routing and account information for ACH transmissions by attaching a voided check or financial institution printout to this authorization. DCSS does no pre-note to verify my information. I will immediately notify DCSS if my banking information changes. I must submit a new authorization form to change my direct deposit. I can stop my direct deposit by notifying the DCSS Hotline or local office. I must notify the DCSS local office of any changes to my address. I must include my name and case number on all correspondence regarding direct deposit. The DCSS Hotline and web site provide the date the DCSS system disbursed my payment; I must verify with my financial institution when the payment is posted to my account and funds are available for withdrawal.

By signing below I signify that I have read and agree to all of the conditions listed above.

Signature:_____ **Date Signed:** _____

*******PLEASE TYPE OR LEGIBLY PRINT ALL INFORMATION BELOW IN INK*******

Section 2: CUSTODIAL PARENT INFORMATION

Name: (As it appears on your GA DDS check)	GA DCSS Case Number (if applicable):	
Social Security Number	Additional GA DCSS Case Numbers:	
Mailing Address		
City:	State:	Zip:
Day-time Telephone Number:	**Email:**	

Section 3: FINANCIAL INSTITUTION INFORMATION

Name of financial institution:		
Routing Number:	Account Number:	Account Type: [ ] Checking [ ] Savings
City:	State:	Telephone:

Section 4: *****FOR DCSS USE ONLY*****

Date received: ___/___/___ Initials:	Date input: ___/___/___ Initials:	Date verified: ___/___/___ Initials:

Please verify all information. Then, mail this completed form along with a voided check or savings account deposit slip to the local child Support Services office.

Check here if this is a "Bank-Card Only" account [_]

For your information: If you have access to the internet, you may view your case and obtain payment information on the Customer Online Services website at **https://services.georgia.gov/dhr/cspp/do/Logon**. First time users are required to register to obtain a user ID and password. Once your case has been registered, you may obtain your IRN by calling the Contact Center at 1-844-MYGADHS (1-844-694-2347 Toll Free) .

Georgia EPPICard Debit MasterCard

The Division of Child Support Services (DCSS) no longer mails child support payments in the form of paper checks. If you did not submit a request to have your child support payments deposited into your checking or savings account, a Debit MasterCard will be mailed to you via first class mail within 7 to 10 business days from the date the first child support payment is posted to your case.

The Georgia EPPICard Debit MasterCard allows you to:

1. Make purchases at merchant locations where MasterCard Debit cards are accepted
2. Get cash back at merchant locations where MasterCard Debit cards are accepted
3. Make bank teller and ATM cash withdrawals at locations where MasterCard is accepted
4. Access your child support payments anywhere in the U.S. where MasterCard Debit cards are accepted

If you do not receive your EPPICard within 7 to 10 business days from the date your first child support payment is posted to your case, please contact Georgia EPPICard Customer Service at 1-800-656-1347. Once you have received and activated your EPPICard you will be able to receive payment alerts by creating an account on the EPPICard website.

Your Georgia EPPICard will expire every 3 years and a new card will be mailed to you.
Please be sure to update your address with DCSS every time your address changes.

For your information: If you have access to the internet, you may view your case and obtain payment information on the Customer Online Services website at **https://services.georgia.gov/dhr/cspp/do/Logon**. First time users are required to register to obtain a user ID and password. Once your case has been registered, you may obtain your IRN by calling the Contact Center at 1-844-MYGADHS (1-844-694-2347 Toll Free)