Georgia Department of Human Services
Division of Child Support Services

DATE: _____

Child Support Case No.:_____

Noncustodial Parent:_____

Custodial Parent: _____

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.

Complete, sign and return the packet in its entirety with all supporting documents to your local Child Support Services office. https://childsupport.georgia.gov/locations

Please review the following circumstances as additional information may be required:

➡ You must provide a certified copy of your order for Support if the Defendant Obligor (NCP) no longer resides in the same county of the original order. A certified copy is obtainable from the Clerk of Court and must be stamped and **"Certified". Failure to provide a certified copy may result in termination of the review.**

➡ If the order is less than 36 months: You **MUST** show that a **Substantial Change in circumstance** has occurred since the original Support amount was set by court order or since the last review was conducted. **You must provide evidence of substantial change in circumstance:**
REASON:_____
_____
_____
_____

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

- ☐ My wages or financial status changed (increase, decrease, lottery winning, inheritance, etc.).
- ☐ At least one of the children in my case turns 18 within 6 months.
- ☐ The other parent's wages or financial status changed (increase, decrease, lottery winning, inheritance, etc.).
- ☐ I am receiving Temporary Assistance for Needy Families (TANF).
- ☐ 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.
- ☐ I am unable to work due to my health or an accident.
- ☐ I have been sentenced to incarceration for more than 180 days.
- ☐ The noncustodial parent and/or dependent child(ren) began receiving social security benefits.
- ☐ Other_____

A $100 modification review fee, if applicable, must be paid by the requesting party when the review is complete and the order is adopted by the court. This fee is waived only if the requesting party is currently receiving TANF and/or Family Medicaid benefits OR their current gross income (before taxes) is $1,261.50 or less per month.

If you have any questions, please call 1-844-MYGADHS (1-844-694-2347 Toll Free). Or you may view your case information on the Customer Service Online website at https://services.georgia.gov/dhr/cspp/do/Logon First time users are required to register to obtain a user ID and password.

I understand and agree that:

- **All forms must be signed and notarized where required** or they will be returned to me, which may cause delays or possible termination of the modification review.
- DCSS only reviews child support and health insurance for modification 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.
- 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.**
- I 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 $1,261.50 per month 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 $1,261.50 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: https://childsupport.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.

Case Number:_____

INFORMATION ABOUT YOU (Please Print All Information)
Important Safety Information

PERSONAL AND FINANCIAL INFORMATION

Name (Last, First, Middle)	Social Security No.	Date of Birth	Relationship to Child(ren)
Address: Street Address	Apt. #	City	State	Zip Code
Home Telephone No. ( )	Cellular Telephone No. ( )	**Do you have custody of the child(ren)?** ☐ **YES** ☐ **NO**	
E-Mail address	Employer Name	Employer Telephone No. ( ) ext	
Employer Address: Street Address	City	State	Zip Code

INFORMATION ABOUT THE OTHER PARTY

Name (Last, First, Middle)	Social Security No.	Date of Birth	Relationship to Child(ren)
Address: Street Address	Apt. #	City	State	Zip Code
Current Employer	Employer Telephone No. ( )	Home Telephone No. ( )	
Employer Address: Street Address	City	State	Zip Code

INFORMATION ABOUT THE CHILD(REN) IN THIS CASE (List only your children with the other party named above.)

Name (Last, First, Middle)	**Sex**	**Social Security Number**	**Date of Birth**	**Place of Birth**

FEDERAL BENEFITS / SOCIAL SECURITY HISTORY

[_] Receives social security disability [_] Receives SSI [_] Receives survivor benefits
[_] Receives military pension or disability [_] Never received ANY of the above benefits
Does the child(ren) receive benefits from parent's account? [_] Yes [_] No If Yes, amount $_____
If yes, type, benefit amount and from which parent?_____

YOUR EMPLOYMENT:

[_] Unemployed [_] Self-employed Type of business:_____

***** If you are self-employed you MUST provide a copy of all applicable tax returns filed for your business, company and/or proprietorship.

IF UNEMPLOYED: (please provide a copy of your separation notice) Dates:

from: ___/___/___ to___/___/___ Reason for job termination: [ ] Quit [ ] Fired [ ] Laid Off

[ ] Other Details:_____

Did you receive: [ ]Unemployment [ ] Disability from: __/__/__ to __/__/__

[ ] Settlement Amount: $ _____

MILITARY STATUS: [_] Never in military service [_] Active [_] Retired [_] Discharged
Branch: _____ Service no: _____ Entry date: ___/___/___
Discharge date: ___/___/___

HAVE YOU EVER BEEN IN PRISON OR ON PROBATION?
[_] Prison history [_] Probation history [_] On probation now

Incarcerated from ____/____/____ to ____/____/____ Probation period to end: ___/___/___
Institution name: _____
Probation / parole officer:_____
Institution address _____Probation / parole officer's#._____

EDUCATIONAL HISTORY:
Schools (High school, Trade, Colleges) attended:

_____
Name Street City State Zip Phone Number

Degree(s)/Certification Obtained:_____

_____
Name Street City State Zip Phone Number

Degree(s)/Certification Obtained:_____

STATEMENT OF EMPLOYMENT AND INCOME HISTORY
(Use to show how your income has changed since the last support amount was ordered)

<u>Instructions:</u> 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: _____/_____/_____

FINANCIAL INFORMATION & EXPENSES

Please provide proof of all income listed below that applies

YOUR GROSS (before any deductions) **MONTHLY INCOME FROM:**	**AMOUNT** (CURRENT INFORMATION)
Salary and Wages (including commissions, bonuses, and overtime) – **5 or more stubs**	$
Self-Employment (**last 2 years taxes**)	$
Pensions and Retirement	$
Social Security Benefits (**Award letter**)	$
Unemployment Benefits	$
Disability and Workers Compensation Benefits	$
Veterans Benefits (**benefits statement**)	$
Other (specify):	$
	$
TOTAL MONTHLY INCOME	$

Medical or Life Insurance Premiums:			**AMOUNT** (CURRENT INFORMATION)
Health Insurance You Pay For Your Child(ren) On This **Order (provide proof of coverage from employer & ALL members covered)**			$
Dental and/or Vision **(provide proof of coverage from employer & ALL members covered)**			$
Life Insurance (where child is the beneficiary)			$
Insurance Company	Policy Number	Child(ren) Covered	
TOTAL MONTHLY PREMIUMS			**$**

YOUR EXPENSE SOURCE:	**AMOUNT** (CURRENT INFORMATION)
Rent or mortgage payment	$
Child care for the child on case - **proof of payments required**	$
Probation/Parole fines	$
Vehicle payment	$
Transportation/visitation costs	$
Child support paid by previous child support order **– copy of order/payment history required**	$
Extraordinary education expenses (i.e. Tuition, books, room or board) **– Proof is required**	$
Child Extraordinary medical expenses (copays, deductibles) **– Proof is required**	$
Special expenses for child rearing (i.e. camp, band, music, art, clubs) **– Proof is required**	$
Other- must explain and provide proof	$
TOTAL EXPENSES	$

Read the statements below. Check the box next to those you believe are true and explain why.

☐ The other parents income has substantially (check one) ☐ increased ☐ decreased since the date of the current child support order.
By how much? $ _____ per _____ Explain why _____

Do you have any other children, not already mentioned in this questionnaire, **who currently live with you and are not subject to a court order?**
☐ Yes ☐ No If yes, complete the box below and provide evidence. **Do not include stepchildren.**

Name (Last, First, Middle)	**Sex**	**Date of Birth**

Do you have any other children, not already mentioned in this questionnaire, **whom you are legally obligated to support?**
☐ Yes ☐ No If yes, complete the box below**. Please attach copy of your court orders and payment history if it is not enforced by GA DCSS.**

Name (Last, First, Middle)	**Sex**	**Date of Birth**

Is there any other information we should consider that has not been covered in this questionnaire? **For example; Special or unusual medical needs of the child(ren) and/or yourself.**

Explain and provide supporting documents

_____

_____

_____

_____

I declare under penalty and perjury, all the information and facts stated are true and to the best of my knowledge and belief. I understand the criminal penalties for making false statements and false swearing under Georgia Law, O.C.G.A §16-10-71 and do hereby attest to the truthfulness of the information provided.

Your signature:_____ Date:____/____/_____

Notary Public signature: _____

Commission expiration date**:** ____/___/____

NOTARY SEAL:

IN THE SUPERIOR COURT OF _____ COUNTY
STATE OF GEORGIA

Georgia Dept. of Human Services, ex. rel.,	§ **Civil Action File No.**
_____	§
_____	§ **Modification of Child Support**
_____	§
_____	§
	§
Plaintiff	§
v.	§
_____	§
and	
_____	
Defendants	

WAIVER OF PERSONAL SERVICE

I understand that I HAVE THE RIGHT TO BE SERVED PERSONALLY by the Sheriff's Department or Process Server with a copy of the following documents:

- Petition to Adopt Agency Recommendation
- Summons, Notice of Hearing and/or Rule Nisi
- Notice to Produce
- Any/all other notices necessary to complete this process.

I do not wish to be personally served. I prefer to receive all documents regarding this modification review, any appeals, decisions, or petitions by regular, first class mail at my legal address, as provided below.

I understand that by signing this waiver, I am giving up the right of personal service. I am freely and voluntarily signing this waiver.

Please mail all documents to this, my MAILING ADDRESS:

_____
Street Address City County State Zip

My LEGAL residence is: **[ ] the same as my mailing address above; or**
[ ] shown below, including my residential county:

_____
Street Address City County State Zip

I also acknowledge that I am responsible for keeping the Division of Child Support Services informed of changes in my home or work addresses. I will mail or hand-deliver all changes to DCSS.

I declare under penalty and perjury, all the information and facts stated are true and to the best of my knowledge and belief. I understand the criminal penalties for making false statements and false swearing under Georgia Law, O.C.G.A §16-10-71 and do hereby attest to the truthfulness of the information provided.

PRINT NAME: _____ Signed: _____

Sworn to and subscribed before me

this _____ day of _____, 20_____.

_____
NOTARY PUBLIC
My Commission Expires: _____
DCSS Case No.: _____

IN THE SUPERIOR COURT OF _____ COUNTY
STATE OF GEORGIA

Georgia Dept. of Human Services, ex. rel.,	§ **Civil Action File No.**
_____	§
_____	§
_____	§
_____	§
Plaintiff	§
v.	§
_____	§
and	
_____	
Defendants	

WAIVER OF PERSONAL SERVICE AND JURISDICTION

I understand that I HAVE THE RIGHT TO BE SERVED PERSONALLY by the Sheriff or Process Server with a copy of the following documents:

- Petition to Adopt Agency Recommendation
- Summons, Notice of Hearing and/or Rule Nisi
- Notice to Produce
- Any/all other notices necessary to complete this process.

I do not wish to be personally served. I prefer to receive all documents regarding this modification review, any appeals, decisions, or petitions by regular, first class mail at my legal address, as provided below.

I understand that by signing this waiver, I am giving up the right of personal service. I am freely and voluntarily signing this waiver.

Please mail all documents to this, my MAILING ADDRESS:

_____
Street Address City County State Zip

My LEGAL residence is: **[ ] the same as my mailing address above; or**
[ ] shown below, including my residential county:

_____
Street Address City County State Zip

I hereby waive specifically any and all other notice in this matter and I agree to submit to the jurisdiction of the above-styled court.

This _____ day of _____, 20___.

_____
Defendant

Sworn to and subscribed before me

this _____ day of _____, 20_____.

_____
NOTARY PUBLIC
My Commission Expires: _____

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 for the child(ren) named

RE: $TARS Case#: _____
Custodian: _____
Children_____
NCP_____

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.

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

Case Child(ren)	**Birthdate**	**Type of Services You Provide**
_____	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: _____ *Average* Weekly cost: $_____

Does the named Custodian pay the full amount of the cost? [_] Yes [_] No (If another party or agency pays part or all of the childcare, please explain):_____

_____
[_] Daycare is provided through DFCS, in the amount of $_____. Custodian pays: $_____
[_] Another person pays (Relationship to child(ren): _____ Amount they pay: $_____
Does the above cost include other children of this Custodian? If so, please name them.
Your Name: _____Title_____
Name of your facility: _____or [_] Home
Daycare Address_____
Phone number: _____

_____
Signature

Please attach a printout of the receipts over the last 12 months