**State of Georgia Local Office Stamp**

**Department of Human Services**



**Division of Child Support Services**

**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 from the list below:**

• Valid driver’s license;

• Any other international government, federal government, state government and local government-issued picture/photo ID including a Green Car or Visa;

• Valid Passport

**Applicants MUST provide:**

 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);

 Social Security cards for all children listed in the application (if available);

 Birth certificates for all children born **OUTSIDE** of Georgia;

 Marriage license (**Note:** In the absence of a license, a sworn statement from the applicant

attesting their marital status at the time of the child’s(ren) conception & birth can be used);

 Signatures on all pages and notarize forms where required;

 Proof of physical custody of a minor child or dependent child;

 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;

 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 1-877-423-4746 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.***

I understand that:

**Applicant Rights and Responsibilities**

• 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;

• 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;

• I agree to 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;

• 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 $25 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 $500.00 of support. My portion of this fee will be taken from the amount of child support collected on behalf of the children;

• 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 fees and/or 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 reapply for services for a minimum period of six (6) months from the date my case was last closed;

• I agree that 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;

• If I should receive payments distributed to me in error, 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;

• My case will not be eligible for closure until all fees and/or overpayments are paid in full;

• If I request case closure during a legal proceeding to establish a support order, I understand that I will be responsible for any fees and costs incurred by DCSS, including but not limited to court costs and service fees, before my case will be closed;

• 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 $15 per federal offset may be assessed to my case;

• I may receive correspondence from DCSS electronically. To ensure confidentiality of such correspondence, I understand that it is my responsibility to provide a secure and active email address;

• I may obtain my case and payment information by calling the Contact Center at 1-877-423-4746, or I may view my case information on the

Customer Service Online website at [https://services.georgia.gov/dhr/cspp/do/Logon.](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.

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  [ ] | Race: |  | Have you ever had a child support case in another state? [ ] Yes [ ] No | | |
| 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** | | | | | | | |
| **Name**  **(Last, First, Middle)** | **SSN** | **Date of Birth** | **Place of Birth**  **(City, State)** | **Sex** | **Race** | **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: | Race: |
| 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)](http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&amp;SID=ff31071c69268a1653f4fa563c82f47f&amp;rgn=div5&amp;view=text&amp;node=45%3A2.1.2.1.4&amp;idno=45)).

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: Supervisor:

Job Title: 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** | **Averag**  **e**  **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:**

• There is no Court document establishing LEGAL paternity for the child listed;

• If paternity is in doubt for some other reason

• The child’s biological parents were not married at the time of conception or birth;

This form is being completed by the following person:

[\_] The ALLEGED FATHER, who is applying for child support services as [\_] The Non Custodial Parent, [\_] The Custodial Parent

[\_] The MOTHER, who is applying for Child Support Services as [\_] The Custodial Parent, [\_] The Non Custodial Parent

[\_] The NON-Parent Custodian (CU) who has custody of the child(ren) and whose information about paternity is limited.

|  |  |  |  |
| --- | --- | --- | --- |
| **Child’s Birth Certificate Name** | | | |
| Last First Middle Date of Birth | | | |
| Sex [ ] Male [ ] Female | Social Security Number | Race | Relationship to Custodial Parent / Custodian |
| Child was conceived in:  City State Country | | | |
| Hospital where child was born:  City State Country | | | |
| Mother's Marital Status at child's birth: [ ]Single  [ ]Married on: / / Husband’s Name:  [ ]Separated on: / / [ ]Divorced on: **/\_\_/** | | | Father's Marital Status at child's birth: [ ]Single  [ ]Married on: / / Wife’s Name:  [ ]Separated on: / / [ ]Divorced on: **/\_\_/** |
| Date child’s parents began sexual relationship: / / Lived together from / / to / / | | | |
| Has Mother ever named anyone else as the father of this child? [ ] Yes [ ] No [ ] Unsure | | | |
| If so, name: | Address: |  |  |
| ***Who is the child’s father?*** |  |  | Is his name on the Birth Certificate? [ ] Yes [ ] No |
| Did the alleged father (NCP) ever sign a Paternity Statement or Paternity Acknowledgment for this child? [ ] Yes [ ] No  **If yes, when: \_/ / What State:** | | | |
| Has NCP provided child support, necessities, or gifts for this child? In what way? | | | |
| Has paternity testing ever been done regarding this NCP? [ ] 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.

Your Signature:

Date:

Notary Public Signature: Commission Expiration Date:

**NOTARY SEAL**

Custodian:

Non-Custodial Parent Name:

Child(ren):

**Notice of Privacy Practices Georgia Department of Human Services Division of Child Support Services**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THE DEPARTMENT AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This notice is effective April 14, 2003. It is provided to you pursuant to provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and related federal regulations. If you have questions about this Notice please contact the Customer Service Section of the Division of Child Support Services (“DCSS”) at the address below.**

The Department of Human Services is an agency of the State of Georgia responsible for numerous programs which deal with medical and other confidential information. Both federal and state laws establish strict requirements for most programs regarding the disclosure of confidential information, and the Department must comply with those laws. The Division of Child Support Services (DCSS) is a division of that Department. For situations where more stringent disclosure requirements do not apply, this Notice of Privacy Practices describes how the Department may use and disclose any Protected Health Information (PHI) for treatment, payment, health care operations and for certain other purposes. **This notice relates only to health information.** It describes your rights to access and control any PHI, and provides information about your right to make a complaint if you believe the Department has improperly used or disclosed any "PHI." Protected health information is information that may personally identify you or the child(ren) and relates to any past, present or future physical or mental health or condition and related health care services. The Department is required to abide by the terms of this Notice of Privacy Practices, and may change the terms of this notice, at any time. A new notice will be effective for all PHI that the Department maintains at the time of issuance. Upon request, the Department will provide you with a revised Notice of Privacy Practices by posting copies at its’ facilities, publication on the Department's website, in response to a telephone or facsimile request to the Privacy Coordinator, or in person at any facility where you receive services from the Department.

**1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Any PHI may be used and disclosed by the DCSS, its’ employees, agents and attorneys for the purpose of providing child support program services to you. Protected health information is routinely needed in determining biological parentage of the child(ren) involved, your ability to work and pay child support, and to determine the appropriate amount of financial support required for the child(ren). The PHI of the child(ren) involved may also be used and disclosed by DCSS for these same purposes.

**Treatment:** Any PHI may be used to provide, coordinate, or manage your child support services, including coordination with a third party that has your permission to have access to any PHI, such as, a health care professional who may be treating you, a health care specialist or laboratory.

**Payment:** Your PHI or that of the child(ren) may be used to obtain payment for the child(ren)’s health care services and/or specialized education needs of the child(ren).

**Health Care Operations:** The Department may use or disclose any PHI to support the business activities of the DCSS, including, but not limited to, quality assessment activities, employee review activities, training, licensing, and other business activities. The Department may use a sign-in sheet at the registration desk at any facility or office where services are provided. You may be asked to provide your name and other necessary information, and you may be called by name in the waiting room when a staff member is ready to see you, and any PHI may be used to contact you about appointments and/or for other operational reasons. Any PHI may be shared with third party “business associates” who perform various activities that assist us in the provision of your child support services.

Other uses and disclosures of any PHI will be made only with your written authorization, which you may revoke in writing at any time, except as permitted or required by law as described below.

**Other Permitted or Required Uses and Disclosures With Your Authorization or Opportunity to Object**

The Department may use and/or disclose any PHI to a court of law, to a family member, relative or any other persons you identify in the

DCSS Authorization Form. You have the opportunity to agree or object to the use and/or disclosure of all or part of any PHI.

**Permitted or Required Uses and Disclosures Without Your Authorization or Opportunity to Object**

The Department may use or disclose any PHI without your authorization when required to do so by law; for public health purposes, to a person who may be at risk of contracting a communicable disease, to a health oversight agency, to an authority authorized to receive

reports of abuse or neglect, in certain legal proceedings, and for certain law enforcement purposes. Protected health information may

also be disclosed without your authorization to a coroner, medical examiner or funeral director, for certain approved research purposes, to prevent or lessen a threat to health or safety, and to law enforcement authorities for identification or apprehension of an individual.

**Required Uses and Disclosures:** Under the law, the Department must make disclosures to you, when required by the Secretary of the Department of Health and Human Services and to investigate or determine the Department's compliance with the requirements of the Privacy Rule at 45 CFR Sections 164.500 et.seq.

**2. YOUR RIGHTS UNDER THE FEDERAL PRIVACY RULE**

The following is a statement of your rights with respect to any PHI and a brief description of how you may exercise these rights:

**a. You have the right to inspect and copy your protected health information.**

Upon written request, you may inspect and obtain a copy of any PHI for as long as the Department maintains the PHI. A reasonable, cost-based fee for copying, postage and labor expense may apply. Under federal law you may not inspect or copy information compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding, or PHI that is subject to a federal or state law prohibiting access to such information.

**b. You have the right to request restriction of your protected health information.**

You may ask in writing that the Department not use or disclose any part of any PHI for the purposes of treatment, payment or healthcare operations, and not to disclose PHI to family members or friends who may be involved in your care. Such a request must state the specific restriction requested and to whom you want the restriction to apply. The Department is not required to agree to a restriction you

request, and if the Department believes it is in your best interest to permit use and disclosure of any PHI, the PHI will not be restricted,

except as required by law. If the Department does agree to the requested restriction, the Department may not use or disclose any PHI

in violation of that restriction unless it is needed to provide emergency treatment.

**c. You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**

Upon written request, the Department will accommodate reasonable requests for alternative means for the communication of confidential information, but may condition this accommodation upon your provision of an alternative address or other method of contact.

The Department will not request an explanation from you as to the basis for the request.

**d. You may have the right to request amendment of any protected health information.**

If the Department created any PHI, you may request in writing an amendment of that information for as long as it is maintained by the

Department. The Department may deny your request for an amendment, and if it does so will provide information as to any further rights you may have with respect to such denial.

**e. You have the right to receive an accounting of certain disclosures the Department has made of any protected health information.**

This right applies only to disclosures for purposes other than treatment, payment or healthcare operations, excluding any disclosures the Department made to you, to family members or friends involved in your care, or for national security, intelligence or notification purposes. Upon written request, you have the right to receive legally specified information regarding disclosures occurring after April 14,

2003, subject to certain exceptions, restrictions and limitations.

**f. You have the right to obtain a paper copy of this notice from the Department**.

**3. COMPLAINTS RELATED TO USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION OR RIGHTS**

You may complain to the Department and to the Secretary of Health and Human Services if you believe your health information

privacy rights have been violated. You may file a complaint, in writing, with the local child support office which maintains any PHI. You must state the basis for your complaint. The Department will not retaliate against you for filing a complaint. You may contact the Associate General Counsel for further information about the complaint process, this notice, or your rights set forth above. Please sign a copy of this Notice of Privacy Practices for the Department's records.

I have received a copy of this Notice on the date indicated below.

Signature

Date:

***DIVISION OF CHILD SUPPORT SERVICES***



«FIELD82»

«FIELD83»

«FIELD84»

«FIELD85», «FIELD86» «FIELD87»

*Telephone: 1-877-423-4746 (DCSS Contact Center - Toll Free)*

Fax: «FIELD290»

**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\*\*\*\*\***

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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**.](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 1-877-423-4746.



***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**](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 1-877-423-4746.