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 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.

Applicant Rights and Responsibilities

I understand that:

- 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.

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)).

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:

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:

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.

_____ Date: _____

Signature

GENERAL TESTIMONY		
Petitioner Social Security Number: Tribal Affiliation (if applicable)	IV-D Case: [ ] [ ] TANF [ ] IV-E Foster Care [ ] Medicaid Only [ ] Former Assistance [ ] Never Assistance	File Stamp
Respondent Social Security Number: Tribal Affiliation (if applicable)	Non IV-D Case: [ ]	
Responding IV-D Case Identifier.	Initiating IV-D Case Identifier.	
Responding Tribunal No. _____	Initiating Tribunal Case Identifier. _____	
Petitioner is: [ ] Obligee [ ] Caretaker Other than Parent [ ] Obligor [ ] Foster Care Respondent is: [ ] Obligee [ ] Caretaker Other than Parent [ ] Obligor [ ] Foster Care		
_____ being duly sworn, under penalties of perjury, testifies as follows: Name (First, Middle, Last)		

I. Personal Information About Child(ren)'s Mother [ ] See Section X

A.1. Mother is: [ ] Obligee [ ] Obligor	2. [ ] Nondisclosure Finding Attached

3. Full Name (First, Mid, Last; include nickname, alias, maiden name, former married name, etc.)

4. Home Address [ ] Confirmed_____(date)	5. Social Security Number	6. Date of Birth
	7. Home Phone ( )	8. Work Phone ( )
9. Employer Name & Address [ ] Confirmed_____(date)	10(a). Occupation, Trade or Profession 10(b). Highest Level of Education Attained	
11. Estimated Gross Monthly Earnings $	12. Other Monthly Income (& source) $	
13. Real or Personal Property (type & location)		

B. Physical Description of Child(ren)'s Mother (Attach photo if available.)

1. Race	2. Height	3. Weight	4.Hair Color	5. Eye Color

C. Present Marital Status of Child(ren)'s Mother

1. [ ] Married	2. [ ] Single	3. [ ] Living with Non-Marital Partner	
4. [ ] Divorced	5. [ ] Legally Separated	6. [ ] Separated	7. [ ] Unknown

Link to Intergovernmental General Testimony Instructions

GENERAL TESTIMONY, PAGE 2	Initiating IV-D Case Identifier. «FIELD52»
D. Information about Current Spouse or Partner of Child(ren)'s Mother	
1. Name of Current Spouse or Partner (First, Mid, Last)	2. Is Current Spouse/Partner Employed? [ ] Yes [ ] No [ ] Unknown
3. Name and Address of Spouse's/Partner's Employer	4. Spouse's/Partner's Estimated Gross Monthly Earnings $

E. Is the child(ren)'s mother responsible for dependents other than those listed in Section V (pages 4 & 5)?
[ ] Yes [ ] No [ ] Unknown (If yes, provide information below.)

1.	a. Full Name (First, Mid, Last)	b. Date of Birth
	c. Relationship	d. Living With:
	e. Source of Support/Income	f. Monthly Amount; Gross: $ Net: $
2.	a. Full Name (First, Mid, Last)	b. Date of Birth
	c. Relationship	d. Living With:
	e. Source of Support/Income	f. Monthly Amount; Gross: $ Net: $
3.	a. Full Name (First, Mid, Last)	b. Date of Birth
	c. Relationship	d. Living With:
	e. Source of Support/Income	f. Monthly Amount; Gross: $ Net: $

II. Personal Information About Child(ren)'s Father [ ] See Section X

A.1. Father is: [ ] Obligee [ ] Obligor	**2.** [ ] Nondisclosure Finding Attached
3. Full Name (First, Mid, Last; include nickname, alias):	
4. Home Address [ ] Confirmed ____/___/____ (date)	**5**. Social Security Number / **6.** Date of Birth
	7. Home Phone / **8.** Work Phone
9. Employer Name & Address [ ] Confirmed ____/___/____ (date)	**10(a)**. Occupation, Trade or Profession
	10(b). Highest Level of Education Attained
11. Estimated Gross Monthly Earnings $	**12.** Other Monthly Income (& source): $
13. Real or Personal Property (type & location)	

B. Physical Description of Child(ren)'s Father (Optional: Attach photo if available.)

Race	Height	Weight	Hair Color	Eye Color

GENERAL TESTIMONY, PAGE 3	Initiating IV-D Case Identifier/No.

C. Present Marital Status of Child(ren)'s Father

1. [ ] Married	2. [ ] Single	3. [ ] Living with Non-Marital Partner	
4. [ ] Divorced	5. [ ] Legally Separated	6. [ ] Separated	7. [ ] Unknown

D. Information about Current Spouse or Partner of Child(ren)'s Father

1. Name of current Spouse or Partner (First, Mid, Last)	**2**. Is Current Spouse/Partner Employed? [ ] Yes [ ] No [ ] Unknown
3. Name and Address of Spouse's/Partner's Employer	**4**. Spouse's/Partner's Estimated Gross Monthly Earnings $

E. Is the child(ren)'s father responsible for dependents other than those listed in Section V (pages 4 & 5)?
[ ] Yes [ ] No [ ] Unknown (If yes, provide information below.)

1.	a. Full Name (First, Mid, Last)	b. Date of Birth
	c. Relationship	d. Living With:
	e. Source of Support/Income	f. Monthly Amount; Gross: $ Net: $
2.	a. Full Name (First, Mid, Last)	b. Date of Birth
	c. Relationship	d. Living With:
	e. Source of Support/Income	f. Monthly Amount; Gross: $ Net: $
3.	a. Full Name (First, Mid, Last)	b. Date of Birth
	c. Relationship	d. Living With:
	e. Source of Support/Income	f. Monthly Amount; Gross: $ Net: $

III. Personal Information About Caretaker Other than Parent [ ] See Section X

1. Caretaker's Relation to Child is: [ ] Has legal custody/guardianship of child	2. [ ] Nondisclosure Finding Attached

3. Full Name (First, Mid, Last; include nickname, alias, maiden name, former married name, etc.)

4. Home Address [ ] Confirmed ____/___/____(date)	**5**. Social Security Number	**6.** Date of Birth	**7**. Sex: [ ] M [ ] F
	8. Home Phone ( )	**9.** Work Phone ( )	
10. Employer Name & Address [ ] Confirmed____/___/____ (date)	**11(a)**. Occupation, Trade or Profession **11(b)**. Highest Level Of Education Attained		
12. Estimated Gross Monthly Earnings $	**13.** Other Monthly Income (& source) $		
14. Date Child(ren) Began Residing With Caretaker			

GENERAL TESTIMONY, PAGE 4 Initiating IV-D Case Identifier/No.

IV. Legal Relationship of Parents [ ] See Section X

1. [ ] Never married to each other **2**. [ ] Married on _____in _____
Date County/State
3. [ ] Married by common law for the period _____in_____
Dates County/State
4. [ ] Separated on _____ **5**. [ ] Divorced on _____in_____
Date Date County/State
6. [ ] Legally separated on _____in_____
Date County/State
7. [ ] Divorce pending in_____ **8**. [ ] Support Order Entered on _____
County/State Date
9. [ ] No support order **10**. [ ] Other_____

11. Tribunal & Location (Divorce, Legal Separation, Support Order):

V. Dependent Child(ren) in this Action [ ] See Section X

A. List obligor's (named on page 1 of this form) child(ren) only. [ ] Nondisclosure Finding Attached

1.	**a**. Full Legal Name (First, Mid, Last)		**f**. Paternity Established? [ ] Yes (check how) [ ] No
	b. Address		[ ] By order [ ] By voluntary acknowledgement [ ] By adoption [ ] By conclusive marital presumption [ ] Other:
			g. Support Order Established? [ ] Yes [ ] No
	c. Social Security Number:		**h**. Living with Petitioner? [ ] Yes [ ] No
	d. Sex	**e**. Date of Birth	
2.	**a**. Full Legal Name (First, Mid, Last)		**f**. Paternity Established? [ ] Yes (check how) [ ] No
	b. Address		[ ] By order [ ] By voluntary acknowledgement [ ] By adoption [ ] By conclusive marital presumption [ ] Other:
			g. Support Order Established? [ ] Yes [ ] No
	c. Social Security Number:		**h**. Living with Petitioner? [ ] Yes [ ] No
	d. Sex	**e**. Date of Birth	
3.	**a**. Full Legal Name (First, Mid, Last)		**f**. Paternity Established? [ ] Yes (check how) [ ] No
	b. Address		[ ] By order [ ] By voluntary acknowledgement [ ] By adoption [ ] By conclusive marital presumption [ ] Other:
			g. Support Order Established? [ ] Yes [ ] No
	c. Social Security Number		**h**. Living with Petitioner? [ ] Yes [ ] No
	d. Sex	**e**. Date of Birth	

GENERAL TESTIMONY, PAGE 5 Initiating IV-D Case Identifier/No.

4.	**a**. Full Legal Name (First, Mid, Last)		**f**. Paternity Established? [ ] Yes (check how) [ ] No
	b. Address		[ ] By order [ ] By voluntary acknowledgement [ ] By adoption [ ] By conclusive marital presumption [ ] Other:
			g. Support Order Established? [ ] Yes [ ] No
	c. Social Security Number:		**h**. Living with Petitioner? [ ] Yes [ ] No
	d. Sex	**e**. Date of Birth	

B. The child(ren) began residing in _____ on _____.
State Month/Year

VI. Medical Insurance [ ] See Section X

1. Is obligor required by a child support order to provide medical insurance for the child(ren)? [ ] Yes [ ] No

2. Is obligor required by a child support order to provide medical insurance for the obligee? [ ] Yes [ ] No

3. Medical coverage for dependent child(ren) listed in Section V and/or the obligee is provided by:

	For dependent child(ren)	For obligee	Obligee's Insurance Company:	
Obligee	[ ]	[ ]		
Obligor	[ ]	[ ]	Policy Number:	
State Medicaid	[ ]	[ ]	Obligor's Insurance Company:	
Obligee's Employer	[ ]	[ ]		
Obligor's Employer	[ ]	[ ]	Policy Number:	
Other _____	[ ]	[ ]	Other Insurance Company:	
Unknown	[ ]	[ ]		
No Coverage	[ ]	[ ]	Policy Number:	

4. The monthly cost paid by the obligee for medical insurance for the obligor's child(ren) only is: $_____
(If medical insurance is provided by the obligee or obligee's employer, skip to number 6).

5. Obligee can purchase needed medical insurance at a monthly cost of: $_____

6. Were the children ever covered by medical insurance provided by the obligor/obligee or his/her current employer?
[ ] Yes [ ] No [ ] Unknown

7. Do any of the obligor's children have special needs or extraordinary medical expenses not covered by insurance?
[ ] Yes [ ] No
(If "Yes", please indicate the child involved and the type of special needs/extraordinary medical expenses and the related costs. Attach proof.)

8. Is the obligee asking to be reimbursed for medical coverage by obligor? [ ] Yes [ ] No [ ] Unknown

VII. Support Order and Payment Information [ ] See Section X

1. Does a support order exist? (If "No", skip to page 7.) [ ] Yes [ ] No

2. Did child(ren) reside with the obligor at anytime during the period for which support is sought, except during periods of visitation specified by a tribunal's order? [ ] Yes [ ] No If "Yes", Identify Period of Residency:
From: ___________________Thru:___________________

3. If a modification is being requested, indicate the basis for the request below:
   - [ ] The earnings of the obligor have substantially increased or decreased.
   - [ ] The earnings of the obligee have substantially increased or decreased.
   - [ ] The needs of a party or of the child(ren) have substantially increased or decreased.
   - [ ] Other, Explain ____

4. Describe all current support orders (include all pertinent orders and modifications). NOTE: if more than three (3) orders exist, attach complete description as below for each.

Date of Order	Current Amount $	Per Month/Week/etc.	Toward Arrears $	Per Month/Week/etc
Unpaid Interest $______________ as of ______________(date)		Total Arrears $______________ as of _______________(date)		
Tribunal's Name & Address				

Date of Order	Current Amount $	Per Month/Week/etc.	Toward Arrears $	Per Month/Week/etc
Unpaid Interest $______________ as of ______________(date)		Total Arrears $______________ as of _______________(date)		
Tribunal's Name & Address				

Date of Order	Current Amount $	Per Month/Week/etc.	Toward Arrears $	Per Month/Week/etc
Unpaid Interest $______________ as of ______________(date)		Total Arrears $______________ as of _______________(date)		
Tribunal's Name & Address				

5. Unpaid Medical Cost Reimbursement $__________________________as of ___________________________________
   (attach documentation) Date

6. Other Unpaid Costs and Fees $__________________________as of ___________________________________
   Date
   Explain: ____

7. Direct Payments to Obligee: [ ] Affidavit from Obligee Attached [ ] No Direct Payments Received

8. Obligor's support payment history:

[ ] Certified copy of tribunal/agency payment history is attached. (Skip to page 7)
[ ] Payment history provided on page 6a
[ ] N.A.; responding State does not require. (Skip to page 7)

From (Year) to (Year):	Agency Which Prepared Audit/Payment History:

GENERAL TESTIMONY, PAGE 6a Initiating IV-D Case Identifier/No.

Obligor's Payment History Adjudicated Arrears $_____ as of _____
Date of Order

Year: _____ Year: _____

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

Year: _____ Year: _____

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

Total of Adjudicated and Accrued Arrears $_____ as of _____
Date

_____

Date Name/Title, Agency or Tribunal Signature

_____

Sworn to and Signed before me this Date, County, State Notary Public, Official and Title Commission Expires

VIII. TANF / Foster Care/Medical Assistance Status [ ] See Section X

[If no TANF/Foster Care/Medical Assistance benefits were paid, skip to Section IX.]

1. Period during which TANF/Foster Care was paid:

From:_____/_____ To:_____/_____by:_____
First month year Last month year State

2. Total amount of TANF/Foster Care paid: $_____ as of _____
Date

3. Medical assistance related to prenatal, postnatal, or general expenses was paid in the amount of $_____by: _____.
Agency or Person

IX. Financial Information [ ] See Section X

Information required varies based on responding State's guidelines. Updates may be required.

A. Monthly Income from All Sources:

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

2. Gross Monthly Income Amounts			Petitioner	Current Spouse/Partner	Obligor's Dependent(s)
	a) Public Assistance		$_____	$_____	$_____
		i) SSI	$_____	$_____	$_____
		ii) Family Assistance	$_____	$_____	$_____
		iii) Other	$_____	$_____	$_____
	b) Base pay salary, wages		$_____	$_____	$_____
	c) Overtime, commissions, tips, bonuses, part-time		$_____	$_____	$_____
	d) Unemployment compensation		$_____	$_____	$_____
	e) Worker's compensation		$_____	$_____	$_____
	f) Social Security Disability		$_____	$_____	$_____
	g) Social Security Retirement		$_____	$_____	$_____
	h) Dividends and interest		$_____	$_____	$_____
	i) Trust/Annuity Income		$_____	$_____	$_____
	j) Pensions, retirement		$_____	$_____	$_____
	k) Child support		$_____	$_____	$_____
	l) Spousal support/alimony		$_____	$_____	$_____
	m) All other sources		$_____	$_____	$_____
Explain "other sources": _____					
3. **Total Gross Monthly** (lines "2a" through "2m")			$_____	$_____	$_____
4. Deductions From Gross		a) Federal Income Tax	$_____	$_____	$_____
		b) State Income Tax	$_____	$_____	$_____
		c) Local Tax	$_____	$_____	$_____
		d) F.I.C.A	$_____	$_____	$_____

5. **Adjusted Net Monthly** (line "3" minus lines "4a through 4d")	Petitioner	Current Spouse/Partner	Obligor's Dependent(s)
	$_____	$_____	$_____
6. Other Deductions			
a) Savings	$_____	$_____	$_____
b) Loan Repayment	$_____	$_____	$_____
c) Mandatory Retirement	$_____	$_____	$_____
d) Non-mandatory Retirement	$_____	$_____	$_____
e) Medical Insurance	$_____	$_____	$_____
f) Union Dues	$_____	$_____	$_____
g) Other (specify)	$_____	$_____	$_____
7. **Net Monthly Income** (line "5" minus lines "6a through 6g")	$_____	$_____	$_____
8. **Gross Income Prior Year**	$_____	$_____	$_____

Attach three most recent pay stubs from each current employer for all parties shown.

B. Monthly Expenses	Petitioner	Obligor's Dependents
1) Rent/Mortgage	$_____	$_____
2) Homeowners/Renters Insurance	$_____	$_____
3) Home Maintenance & Repair	$_____	$_____
4) Heat	$_____	$_____
5) Electricity/Gas	$_____	$_____
6) Telephone	$_____	$_____
7) Water/Sewer	$_____	$_____
8) Food	$_____	$_____
9) Laundry/Cleaning	$_____	$_____
10) Clothing	$_____	$_____
11) Life Insurance	$_____	$_____
12) Medical Insurance	$_____	$_____
13) Uninsured Extraordinary Medical (attach documentation)	$_____	$_____
14) Other Uninsured Health-Related Expenses	$_____	$_____
15) Auto Payment	$_____	$_____
16) Auto Insurance	$_____	$_____
17) Auto Expense	$_____	$_____
18) Other Transportation	$_____	$_____
19) Child Care		
Provider: _____		
Frequency: _____ Per _____		
20) Support Payments, actual amount paid	$_____	$_____
21) Internet service	$_____	$_____
22) Other; Explain:		
Total Monthly Expenses (lines 1 through 22)	$_____	$_____

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C. Assets:

1.) Real Estate					
	Address				
	Owner(s)				
	Title				
$_____	**minus**	$_____	=	$ _____	
Assessed Value		Mortgage(s)			
2) IRA, Keogh, Pension, Profit Sharing, Other Retirement Plans					
_____				$ _____	
Institution or Plan Name and Account No.					
_____				$ _____	
Institution or Plan Name and Account No.					
3.) Tax Deferred Annuity Plan(s)				$ _____	
4.) Life Insurance Present Cash Value				$ _____	
5.) Savings & Checking Accounts, Money Market Accounts & CDs					
_____				$ _____	
Institution Name and Account Number				$ _____	
_____					
Institution Name and Account Number					
6.) Automobiles/Vehicles					
_____	_____	_____	$_____ minus	$ _____	= $_____
Make	Model	Year	Estimated Value	Loan Balance	
_____	_____	_____	$_____ minus	$ _____	= $_____
Make	Model	Year	Estimated Value	Loan Balance	
_____	_____	_____	$_____ minus	$ _____	= $_____
Make	Model	Year	Estimated Value	Loan Balance	
7) Other (e.g., Personal Property, Securities, etc). Describe: _____					$_____
Total Assets (lines 1 through 7)					$_____

GENERAL TESTIMONY, PAGE 10 Initiating IV-D Case Identifier/No.

X. Other Pertinent Information (Attach additional sheets if necessary).

XI. Verification

[ ] Attached are the required number of copies of all support orders for the case.

Also attached and incorporated by reference are:

[ ] Copy of the certified child support payment records.
[ ] Copies of three most recent pay stubs from current employer.
[ ] Copies of bills for prenatal, postnatal and general health care of mother and child.
[ ] Assignment or subrogation of support rights.
[ ] "Affidavit in Support of Establishing Paternity" for each child whose paternity is at issue.
[ ] Copy of child(ren)'s birth certificate(s).
[ ] Acknowledgment of parentage.
[ ] Documentation of legal custody/guardianship of child(ren).
[ ] Documentation that children are in foster care.
[ ] Other:_____

All of the information and facts contained in this General Testimony are true and correct to my/our best knowledge and belief.

_____	_____	_____
Date	Petitioner (Name/Title)	Signature
_____	_____	_____
Date	Agency Representative (Name/Title)	Signature

_____	_____	_____
Sworn to and Signed Before me This Date	Notary Public, Tribunal/Agency County/State	Commission Expires Official and Title

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*****

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 1-877-423-4746.

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. 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.