DIVISION OF CHILD SUPPORT SERVICES
Telephone: 1-844-MYGADHS (1-844-694-2347) DCSS Contact Center - Toll Free)

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

REQUEST FOR REVIEW OF CHILD SUPPORT ORDER

Instructions

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

Except for your signature, print your responses. Use a black or blue ink ball point pen only. Sign and return all required forms to your Child Support Services office.

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

Complete and return the following forms:

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

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

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

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

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

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

I understand and agree that:

- All forms must be signed and notarized where required or they will be returned to you, which may cause delays or possible termination of the modification review.
- DCSS only reviews child support and health insurance modifications for the children.
- DCSS does not represent me or the other party to my support order.
- DCSS uses information I provide to establish, modify, or enforce child support.
- After DCSS reviews my request, DCSS will determine if my case meets requirements for modification.
- Both parties have the right to have an attorney represent them in court under the provision of GA law O.C.G.A. 19-6-19.
- The judge decides the start date.
- I have the right to ask a court to modify or adjust my support order on my own.
- My modified or adjusted support order can result in higher, lower or remain unchanged support payments.
- Must notify DCSS of any changes to my name, address, phone number(s) or any other information that is needed to proceed with my request for a review and modification.
- I understand that a $100 modification fee will be required if my monthly gross income (before taxes) is equal to or greater than $1,000 and I requested the review and modification. The fee is waived if I am receiving TANF. If I receive Medicaid for my children and not for myself and my monthly gross income (before taxes) is equal to or greater than $1000 per month the fee must be paid. The fee, if applicable, will be required when the review is complete and the order is adopted by the court.
- I understand that I am responsible for providing proof of my income and expenses. Failure to provide the required information within the specified time frame(s) may result in termination of the review process or an Agency Recommendation that may adversely affect my interests.
- I understand that legal documents including the Agency Recommendation and a petition will be personally served to me by my local sheriff's department or process server at my place of residence unless I sign and return the attached Waiver of Personal Service.

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

_____ _____

Date Signature

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

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

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

Review and Modification Checklist

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

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

Income Verification:

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

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

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

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

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

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

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

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

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

If you are providing vision and /or dental coverage

____ Copy of the insurance card verifying coverage

____ Insurance company name, address, phone number, sponsoring employer, (if group coverage) name or the person(s) providing insurance.

____ Group number and policy number

____ Names of covered members

____ Total cost of insurance and frequency (monthly, weekly, bi-weekly, etc.)

____ Cost of insurance for the child or children's portion on this case

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

____ Proof of life insurance from your insurance company with the child or children listed as beneficiaries

____ Proof of the monthly cost of the life insurance

If you have expenses associated for work related child care

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

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

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

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

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

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

____ Separation notice from my last employer detailing my circumstances for job loss

____ Statement detailing the reasons for your current financial instability if currently employed

____ If you are currently disabled, please provide a statement from your doctor noting if your disability is permanent or temporary. If temporary, we will need the date of your anticipated return to work.

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

a.) An order of visitation. To be a deviation it may have to be extended visitation that is more than the usual amount. Joint or shared physical custody;

b.) Insurance for the child, including health, dental, vision or life insurance where the child is the beneficiary;

c.) Work related child care costs;

d.) High income of either parent;

e.) Low income of either parent (demonstrating extreme economic hardship or no earning capacity);

f.) Substantial Travel Expenses for visitation;

g.) Alimony;

h.) Mortgage payments made to the custodial parent for the benefit of the child;

i.) Permanency or Foster Care Plan;

j.) Extraordinary expenses for the child(ren) like educational costs as well as special expenses for raising the child and extraordinary medical expenses.

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

PERSONAL / FINANCIAL AFFIDAVIT

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

PERSONAL INFORMATION:

Your name:

_____

Last First Middle Maiden

Other married names, nicknames, etc:

_____

Marital status: [_] Single [_] Married Spouse: _____ [_] Divorced

Social Security Number: _____ Sex: [_] Male [_] Female

Date of birth: ____/____/____ Place of birth: _____

City State County Country

Eyes: _____ Hair: _____ Weight: _____ Height: ____ft ____in

Home address: _____

Street address City State County Zip

Mailing address:_____

Street address City State County Zip

At this address since: ___/___/___ E-mail: _____

Home phone #: _____ Cell phone #: _____ Work phone#:_____

Last permanent address: _____

Street address City State County Zip

Driver's license no: _____ State: _____ Vehicle make/model/year: _____

License tag: _____ State: _____

FEDERAL BENEFITS / SOCIAL SECURITY HISTORY

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

ADOPTION / FOSTER CARE:

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

YOUR EMPLOYMENT:

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

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

IF UNEMPLOYED: (please provide a copy of your separation notice) Dates: from: __/__/__ to __/__/__
Reason for job termination: [ ] Quit [ ] Fired [ ] Laid Off [ ] Other Details: _____

Did you receive: [ ] Disability from: __/__/__ to __/__/__ [ ] Settlement Amount: $ _____

Employer:_____ Job title:_____

Contact person:_____ 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

INSURANCE INFORMATION:

Do you provide health insurance? [_]Yes [_] No Total number of people included in policy? ___ Monthly Cost: $_____

Each child's portion: $_____ Who is currently covered by Health Insurance?_____

Insurance company name:_____

Insurance company phone no.: (_____)_____-_____ Policy / Group No.:_____

Address:_____

Street address City State County Zip

Do you provide life insurance with the child on this case as the beneficiary? [_]Yes [_] No Monthly Cost: $_____

Do you provide dental insurance? [_]Yes [_] No Monthly Cost for children included in this case: $_____

Do you provide vision insurance? [_]Yes [_] No Monthly Cost for children included in this case: $_____

NAME OF BANK / CREDIT UNION:

_____ **Account type & no.:**_____

_____ **Account type & no.:**_____

FAMILY HISTORY: [Note: even if parents are deceased]

Your mother: _____ Phone no.: (_____)_____-_____

Date of birth: ____/____/____ Place of birth: _____[_] Deceased on ____/____/____

Address:

_____

Street address City State County Zip

Your father: _____ Phone no.: (_____)_____-_____

Date of birth: ____/____/____ Place of birth: _____[_] Deceased on ____/____/____

Address:_____

Street address City State County Zip

Other close relative/Family/Friends: _____ Relationship: _____

Address: _____

Street address City State County Zip

Phone number or other contact address:_____

MILITARY STATUS: [_] Never in military service [_] Active [_] Retired [_] Discharged

Branch: _____ Service no: _____ Entry date: ___/___/___ Discharge date: ___/___/___

HAVE YOU EVER BEEN IN PRISON OR ON PROBATION?

[_] Prison history [_] Probation history [_] On probation now

Incarcerated from ____/____/____ to ____/____/____ Probation period to end: ___/___/___

Institution name: _____ Probation / parole officer:_____

Institution address:_____ Probation / parole officer's no.: _____

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.

_____

EDUCATIONAL HISTORY:

Schools (High school, Trade, Colleges) attended:

_____

Name Street City State Zip Phone Number

Your Financial Summary

Gross Income Source (before taxes)	Average Monthly Gross Amount	Expense Source	Average Monthly Gross Amount
Salary / Wages (do not include TANF)	$	Rent or mortgage payment	$
Commissions, fees & tips	$	Utilities (electric, natural / propane gas, telephone)	$
Self-Employment Income [Refer to O.C.G.A. §19-6-15 (f)(1)(B) for details]	$	Child care ***(proof is required)***	$
		Alimony Paid	$
Bonuses	$	Food	$
Overtime Payments	$	Medical bills or expenses (not covered by insurance) (proof is required)	$
Severance Pay	$	Probation / parole fines	$
Recurring income from Pensions or retirement plans	$	Vehicle payment	$
Interest Income	$	Clothing	$
Income from dividends	$	Transportation/Visitation costs	$
Trust income	$	Child support paid by previous court order	$
Income from annuities	$	Property taxes	$
Capital Gains	$	Recreation	$
Social Security Disability or Retirement (Do not include SSI or payment for children)	$	Insurance (Health) ***(proof is required)***	$
Worker's Compensation benefits	$	Insurance (Life) ***(proof is required)***	$
Unemployment Compensation benefits	$	Insurance (Automobile, Homeowners)	$
Judgments from Personal Injury or other Civil Cases	$	Insurance (Dental/Vision) ***(proof is required)***	$
Gifts (cash or other gifts that can be converted to cash)	$	Bankruptcy	$
Prizes / Lottery winnings	$	Extraordinary Educational Expenses (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:**	$

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

Your signature:_____ SSN _____-____-_____ Date:____/____/_____

Notary Public signature: _____ Commission expiration date: ____/____/_____

NOTARY SEAL:

Confidential Information Form

☐ Divorce/Separation//Non-parental Custody/Paternity/Modifications ☐ Other

☐ Information Change (Check if you are updating information)

☐ **A restraining order or protection order is in effect protecting ☐ the non-custodial parent ☐ the custodial parent ☐ the children.**

The following information about the parties is required in all cases:
(**Use an additional Confidential Information Form to list additional parties or children**)

[ ] Non-Custodial Parent [ ] Custodial Parent [ ] Non-Parent Custodian

Name (Last, First, Middle)		
Race	Sex	Birth date

Driver's Lic. or Identicard (# and State)	Employer
Mailing Address (P.O. Box/Street, City, State, Zip)	Employer Address and Phone Number:
Relationship to Child(ren)	Your Phone Number: Your E-mail address:

The following information is required if there are children involved in the proceeding.

1) Child's Name (Last, First, Middle)
Child's Race/Sex/Birthdate
Child's Present Address or Whereabouts
2) Child's Name (Last, First, Middle)
Child's Race/Sex/Birthdate
Child's Present Address or Whereabouts

List the names and present addresses of the persons with whom the child(ren) lived during the last five years:

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

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

Additional information:_____

_____

_____

☐ Additional Confidential Information Form attached.

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

_____.

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

_____

Signature

DAYCARE VERIFICATION FORM

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

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

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

Thank you, DCSS Representative

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

Case Child(ren)	**Birthdate**	**Type Of Services You Provide**
_____,	DOB:_____	[_] Daycare [_] Afterschool [_] Summer Care
_____,	DOB:_____	[_] Daycare [_] Afterschool [_] Summer Care
_____,	DOB:_____	[_] Daycare [_] Afterschool [_] Summer Care
_____,	DOB:_____	[_] Daycare [_] Afterschool [_] Summer Care
_____,	DOB:_____	[_] Daycare [_] Afterschool [_] Summer Care

What is the COST\Type of care you provide for the named child(ren):

[_] Daily, such as for preschoolers — Weekly Cost: $_____

[_] Afterschool and holidays — Weekly Cost: $_____

[_] Summer Care — Weekly Cost: $_____

[_] Irregularly How often: _____ — *Average* Weekly cost: $_____

Does the named Custodian pay the full amount of the cost? [_] Yes [_] No

(If another party or agency pays part or all of the childcare, please explain):_____

[_] Daycare is provided through DFCS, in the amount of $_____. Custodian pays: $_____

[_] Another person pays (Relationship to child(ren): _____ Amount they pay: $_____

Is it your understanding that the Custodian is working or in classes during the period you provide care: [_] Yes [_] No

Where: _____

Does the above cost include other children of this Custodian? If so, please name them.

Your Name: _____Title_____

Name of your facility: _____or [_] Home Daycare

Address_____

Phone number:_____

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

INFORMATION AFFIDAVIT

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

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

_____

_____

_____

_____

_____

_____

_____

_____

Were the parents of the case child(ren) divorced from one another? [_] No, [_] Never married
[_] Yes, County:_____, State:_____ Year:_____ [_] Still married, not yet divorced

Please indicate the number of Documents you have attached to PROVE the above statements: _____

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

So sworn and affirmed,

Your Signature:_____ SSN____-____-_____ Date: ___/____/___

Notary Public Signature: _____ Commission Expiration Date**:**

___/_____/____

NOTARY SEAL:

STATEMENT OF MEDICAL NEED\COST

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

THIS INFORMATION IS REQUIRED:

Medical Insurance provided for the children : (CHECK **all** known sources of medical insurance for these children)

[_]NCP provides: [_]Medical; [_]Dental; [_]Vision; [ ]Life; Insurance Co:_____ Does CP have card? [_]No [_]Yes

[_]CP provides: [_]Medical; [_]Dental; [_]Vision; [ ]Life; Insurance Co:_____ _____ [_]Medicaid [_]Peach Care

[_]YOUR Spouse provides: [_]Medical; [_]Dental; [_]Vision; [ ]Life; Insurance Co:_____ Insurance cost per pay period: $_____

Extraordinary Medical Expenses: [ ] Co-payments, Amounts: _____; [ ] Deductibles, Amounts: _____

Military Medical Benefits for the case child(ren), based on current, reserves, or retired status:

Military Medical Benefits [_] ARE \ [_]ARE NOT available for the named child(ren) As provided by [_]NCP [_]CP [_] Your Spouse's military benefits

If Spouse provides insurance; Spouse's Name:_____ Spouse's employer:_____ Work Phone:_____

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

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

(Make additional copies of this form as needed)

Patient's Name: _____Relationship to You: _____

Medical Condition: _____Date of (injury\first treatment): _____

How long is this expected to last: _____

How does this condition affect the patient's ability to function normally: _____

What kind of continued treatment is included: _____

_____

Name all REGULAR monthly office visits, medications, and treatments which this condition require _____

_____

What is the TOTAL monthly cost: $_____How much of this cost is YOUR portion: $_____

Name of primary Physician: _____Doctor's #: (_____)_____

Patient's Name: _____Relationship to You: _____

Medical Condition: _____Date of (injury\first treatment): _____

How long is this expected to last: _____

How does this condition affect the patient's ability to function normally: _____

What kind of continued treatment is included: _____

_____

Name all REGULAR monthly office visits, medications, and treatments which this condition require _____

_____

What is the TOTAL monthly cost: $_____How much of this cost is YOUR portion: $_____

Name of primary Physician: _____Doctor's #: (_____)_____

Signed: _____, [__] CP Date: _____/_____/_____

ATTACH PROOF OF THE MEDICAL EXPENSES, SHOW PORTION <u>NOT</u> COVERED BY INSURANCE.

ATTACH A DOCTOR'S STATEMENT DIAGNOSIS, PROGNOSIS, & LENGTH OF EXPECTED TREATMENT

STATEMENT OF EMPLOYMENT AND INCOME HISTORY

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

Instructions:

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

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

Employer:_____Address:_____

Phone:(____)_____ Job Title:_____ Period of employment: From __/____/___ to ___/____/___

Paid: $_____ per [_]Hr [_]Wk [_]Biwkly [_]Yrly Total of all bonuses, commissions, per diem, etc; received Yrly: _____

Describe actual job duties: _____

Reason for job termination: [_] Quit [_] Fired [_] Laid Off [_]Other Details: _____

_____

Did you receive: [_] Unemployment [_] Disability [_] Settlement Amount: $_____ From: ___/____/___ to __/____/___

Proof of Income for this job: [_] W2's, 1099's, Tax Returns; [_] pay stubs; [_] Other:_____

Proof of why I left this job: [_] Separation Notice; [_] Doctor's or Medical Statements; [_] Other:_____

Employer:_____Address:_____

Phone:(____)_____ Job Title:_____ Period of employment: From ____/____/___ to ____/____/___

Paid: $_____ per [_]Hr [_]Wk [_]Biwkly [_]Yrly Total of all bonuses, commissions, per diem, etc; received Yrly: $_____

Describe actual job duties: _____

Reason for job termination: [_] Quit [_] Fired [_] Laid Off [_]Other Details: _____

_____

Did you receive: [_] Unemployment [_] Disability [_] Settlement Amount: $_____ From: ____/____/___ to __/___/___

Proof of Income for this job: [_] W2's, 1099's, Tax Returns; [_] pay stubs; [_] Other:_____

Proof of why I left this job: [__] Separation Notice; [__] Doctor's or Medical Statements; [__] Other:_____

Employer:_____Address:_____

Phone:(____)_____ Job Title:_____ Period of employment: From ____/____/___ to ____/____/___

Paid: $_____ per [_]Hr [_]Wk [_]Biwkly [_]Yrly Total of all bonuses, commissions, per diem, etc; received Yrly: $_____

Describe actual job duties:_____

Reason for job termination: [_] Quit [_] Fired [_] Laid Off [_]Other Details: _____

_____

Did you receive: [_] Unemployment [_] Disability [_] Settlement Amount: $_____ From: ___/____/___ to ___/____/___

Proof of Income for this job: [_] W2's, 1099's, Tax Returns; [_] pay stubs; [_] Other:_____

Proof of why I left this job: [__] Separation Notice; [__] Doctor's or Medical Statements; [__] Other:_____

Signed: _____, Date: _____/_____/_____

Please indicate the number of Documents attached to PROVE the above statements: _____