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

Local Office Stamp

APPLICANT INSTRUCTIONS

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

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

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

Applicants MUST submit the following with the application:

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

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

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

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

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

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

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

Applicant Rights and Responsibilities

I understand and agree that:

Initial All:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

_____ A $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 debts, including fees and overpayments, that are owed at the time and repay any expenses incurred on my behalf. If my case is closed due to severe non-cooperation, I will not be able to reopen my case or re-apply for services for a minimum period of six (6) months from the date my case was last closed;

_____ If I request case closure during a legal proceeding to establish or enforce a support order and my case is eligible for closure, DCSS will not close my case until all legal actions have been completed;

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

I have received and read all program information describing available services, fees, as well as my rights and responsibilities. I have the right to ask questions before I submit my application. My signature on this document authorizes the Division of Child Support Services to provide necessary and appropriate services on my behalf.

_____ _____

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:**

Paternity Affidavit

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

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

My Name Is _____ and I am the:

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

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

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

I certify that all of the information supplied by me is true and correct to the best of my knowledge and belief. I understand the criminal penalties for making false statements and false swearing under O.C.G.A. §16-10-71 and do hereby attest to the truthfulness of the information provided.

Printed Name: _____

Your Signature: _____ Date: _____

Notary Public Signature: _____ Commission Expiration Date: _____

NOTARY SEAL

DCSS Case Number: «FIELD52»

COURT ORDERS, SUPPORT ORDERS, AND ARREARAGE OWED

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

[ ] There is NO Court Order requiring either parent to pay support for the children of this case, because:		
[ ] I am currently married to the NCP (no divorce)	Marriage Date:	Separation Date:
[ ] I was never married to the NCP. (You MUST complete a Paternity Affidavit for each child of this NCP)		
[ ] The mother of the child(ren) was married when the child(ren) was/were born?	Marriage Date:	Separation Date:
[ ] DIVORCE DECREE [ ] DCSS SUPPORT ORDER [ ] LEGITIMATION ORDER [ ] CUSTODY ORDER		
Filed in County, State of on [ ] NCP not ordered to pay child support.		
Support Ordered Amount: $ per [ ] For each child [ ] For All children		
There is an Arrearage (overdue) of $ as of Complete the attached Arrearage Affidavit*		
[ ] CONTEMPT ORDER [ ] MODIFICATION ORDER [ ] JUVENILE ORDER		
Filed in County, State of on [ ] NCP not ordered to pay child support.		
Support Ordered Amount: $ per [ ] For each child [ ] For All children		
There is an Arrearage (overdue) of $ as of Complete the attached Arrearage Affidavit*		
[ ] URESA / UIFSA ORDER (support order from another state) Note: We must have certified copies		
Filed in County, State of on [ ] NCP not ordered to pay child support.		
Support Ordered Amount: $ per [ ] For each child [ ] For All children		
There is an Arrearage (overdue) of $ as of Complete the attached Arrearage Affidavit*		
[ ] TEMPORARY PROTECTIVE ORDER Note: We must have certified copies		
Filed in County, State of on [ ] NCP not ordered to pay child support.		
Support Ordered Amount: $ per [ ] For each child [ ] For All children		
There is an Arrearage (overdue) of $ as of Complete the attached Arrearage Affidavit*		

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

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

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

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

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

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

I certify that all of the information supplied by me is true and correct to the best of my knowledge and belief. I understand the criminal penalties for making false statements and false swearing under O.C.G.A. §16-10-71 and do hereby attest to the truthfulness of the information provided.

So sworn and affirmed,

My Signature:_____ Date: _____

Notary Public Signature:_____ Commission Expiration Date: _____

NOTARY SEAL:

Nathan Deal, Governor **Robyn A. Crittenden, Commissioner**

Georgia Department of Human Services ▪ Division of Child Support Services ▪ Tanguler Gray-Johnson, Director
Two Peachtree Street, NW ▪ 20th Floor ▪ Atlanta, GA 30303 ▪ 404-657-3851 ▪ 404-657-3326 (Fax)

HIPAA Notice of Privacy Practices
Georgia Department of Human Services

Effective Date: *February 23, 2015*

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

If you have any questions about this notice, please contact:
Georgia Department of Human Services
HIPAA Privacy Officer
HIPAADHS@dhs.ga.gov

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

OBLIGATIONS OF THE DEPARTMENT OF HUMAN SERVICES:

DHS is required by law to:

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

HOW DHS MAY USE AND DISCLOSE HEALTH INFORMATION:

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

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

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

For Health Care Operations. DHS may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that quality care is received and to operate, manage, and administer the functions of the agency. For example, DHS may use and disclose information to make sure the

medical care you receive is of the highest quality. DHS also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

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

Individuals Involved in Your Care or Payment for Your Care. When appropriate, DHS may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. DHS also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

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

SPECIAL SITUATIONS:

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

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

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

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

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

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

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

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

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

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

Law Enforcement. DHS may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

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

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

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

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

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

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

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

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

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

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

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

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to DHS will be made only with your written authorization. If you do provide DHS an authorization, you may

revoke it at any time by submitting a written revocation to the above-referenced Privacy Officer. Upon receipt, DHS will no longer disclose Protected Health Information under the authorization. However, disclosures made in reliance upon your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information DHS has about you:
Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the above referenced HIPAA Privacy Officer. DHS has up to 30 days to make your Protected Health Information available to you and DHS may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. DHS may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. DHS may deny your request in certain limited circumstances. If DHS does deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and DHS will comply with the outcome of the review.

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

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

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

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

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

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

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may request a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled

to a paper copy of this notice. To obtain a paper copy of this notice, please contact the above-referenced HIPAA Privacy Officer.

CHANGES TO THIS NOTICE:

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

COMPLAINTS:

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

Georgia Department of Human Services
HIPAA Privacy Officer
HIPAADHS@dhs.ga.gov

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

_____

_____

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

_____ _____

Signature Date

_____

Print Name

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

GENERAL TESTIMONY		
Petitioner Social Security Number: Tribal Affiliation (if applicable)	IV-D Case: [ ] [ ] TANF [ ] IV-E Foster Care [ ] Medicaid Only [ ] Former Assistance [ ] Never Assistance	
Respondent Social Security Number: Tribal Affiliation (if applicable)	Non IV-D Case: [ ]	File Stamp

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

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	

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)	$_____	$_____

GENERAL TESTIMONY, PAGE 9 Initiating IV-D Case Identifier/No.

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)	$_____

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 County/State	Notary Public, Tribunal/Agency Official and Title	Commission Expires

DIVISION OF CHILD SUPPORT SERVICES

«FIELD82»
«FIELD83»
«FIELD84»
«FIELD85», «FIELD86» «FIELD87»

Telephone: 1-844-MYGADHS (1-844-694-2347 Toll Free) (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 1-844-MYGADHS (1-844-694-2347 Toll Free) .

Georgia EPPICard Debit MasterCard

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

The Georgia EPPICard Debit MasterCard allows you to:

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

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

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

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