

# Paternity Opportunity Program

## ERROR-FREE Paternity Declarations



To file a valid, error-free Declaration of Paternity with DCSS, make sure these items are complete:

Use only black or blue ink

Print legibly

Child's first and last name

Child's date of birth

Child's county of birth

Father's first and last name

Mother's first and last name

Father's signature and date

Mother's signature and date

Witness or notary's name, date, signature & seal

**STATE OF CALIFORNIA - HEALTH CARE AGENCY**  
**DECLARATION OF PATERNITY**  
DCSS 004-0002  
 INSTRUCTIONS: PLEASE READ PAGE 1 AND 2 BEFORE COMPLETING

**SECTION A - ALL PARTS OF SECTIONS A & B SHALL BE COMPLETED AND EITHER SECTION C OR D WITNESSED. CHANGES CANNOT BE MADE TO THIS FORM ONCE IT IS FILED WITH THE STATE.**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_

Place of Birth: HOSPITAL NAME: \_\_\_\_\_ CITY: \_\_\_\_\_  
 COUNTY: \_\_\_\_\_ STATE: \_\_\_\_\_

Father's Information: NAME OF FATHER - FIRST: \_\_\_\_\_ MIDDLE: \_\_\_\_\_ LAST: \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_  
 CURRENT ADDRESS (NUMBER, STREET, CITY, STATE, ZIP): \_\_\_\_\_

Mother's Information: NAME OF MOTHER - FIRST: \_\_\_\_\_ MIDDLE: \_\_\_\_\_ LAST: \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_  
 CURRENT ADDRESS (NUMBER, STREET, CITY, STATE, ZIP): \_\_\_\_\_

**SECTION B - READ OTHER SIDE BEFORE SIGNING**

I declare under the penalty of perjury under the laws of the State of California that I am the biological father of the child named on this declaration and that the information I have provided is true and correct. I have read and understand the rights and responsibilities described on the back of this form. I understand that by signing this form I am consenting to the establishment of paternity, thereby acquiring these rights. I am assuming all of the rights and responsibilities as the biological father of this child. I wish to be named as the father on the child's birth certificate. I have been fully informed of my rights and responsibilities.

Signature of Father: \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_  
 Signature of Mother: \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

**SECTION C - TO BE COMPLETED BY A WITNESS AT THE HOSPITAL, CLINIC OR OFFICE (PLEASE PRINT AND SIGN)**

NAME OF WITNESS: \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

**SECTION D - TO BE COMPLETED BY A NOTARY PUBLIC IF SECTION C IS NOT WITNESSED ABOVE**

Name of \_\_\_\_\_ County of \_\_\_\_\_  
 State of \_\_\_\_\_  
 Personally appeared \_\_\_\_\_ (print name and title of office)  
 known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) appears subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that he/she/they executed the same in the capacity or capacities so stated, and that he/she/they are the person(s) named in the instrument.

WITNESS my hand and official seal.  
 Signature: \_\_\_\_\_ (SEAL)

DISTRIBUTION: Original White Copy - DCSS Yellow & Pink Copies - Parents Green Copy - Local Child Support Agency

Fill in all spaces and mail original (white page) to:

DCSS-POP UNIT  
 PO BOX 419070  
 RANCHO CORDOVA CA 95741-9070

### Questions?

Call POP toll-free at 1-866-249-0773

E-mail [askpop@dcss.ca.gov](mailto:askpop@dcss.ca.gov)

Click on the POP link at [www.childsup.ca.gov](http://www.childsup.ca.gov)



PATERNITY  
 OPPORTUNITY  
 PROGRAM