Georgia

Changing a Child Support Order in Your State

The information below applies only to Georgia

1. How can a parent find out if he/she has a IV-D child support case in your jurisdiction?

Parents can contact the DCSS "Customer Service Hotline" at 1-844-694-2347 to obtain payment histories, debit card balances, arrears balances, court information (including date and time), license suspensions, and Individual Registration Numbers for accessing online services.

Parents may also check payment information, enter and receive information about their cases, apply for services or make payments online by using the "Customer Online Services" at www.dcss.dhs.georgia.gov. Registered users receive a password to protect confidentiality.

2. How can a parent contact the child support agency? Please provide relevant mailing address, phone numbers and website.

Parents with specific questions about their child support case can call the Customer Service Hotline at 1-844-694-2347 or they can locate a local office's e-mail and mailing address, telephone number, and fax number at http://dcss.dhs.georgia.gov/list-counties.

Georgia Department of Human Services
Division of Child Support Services
2 Peachtree Street, Suite 20-445
Atlanta, Georgia 30303-3142

3. Are any of the modification materials available online? If so, please describe the materials and provide link(s).

Clients can obtain modification materials at http://dcss.dhs.georgia.gov/request-review-support-order. The DCSS website provides clients with the following modification information:

- Information regarding review of support orders which are Less than 36 months old; and
- A review and modification checklist.

In addition, parents can also access the following modification forms:

- Form RAF WEB/2-3 – Request for Review of Child Support Order;
- Form RAF WEB/6-7 – Personal/Financial Affidavit;
- Form RAF WEB/8 – Your Financial Summary
- Form RAF WEB/9-10 – Confidential Information Form;
- Form RAF Web/11 – Daycare Verification Form;
- Form RAF WEB/12 – Information Affidavit;
- Form RAF WEB/13 – Statement of Medical Need\Cost; and
- Form RAF WEB/14 – Statement of Employment and Income History.

4. Under what circumstances may a parent ask for a modification?

Parents can request DCSS for a modification review on a "less than 36 month old Order" by proving that a "substantial change in circumstances" has occurred since the last order, or since the last modification was completed.

Examples of substantial changes for either party include:

- Diagnosis of a serious illness or an accident that impacts the parent's ability to work and is expected to last for over a year;
- Parent suffers a 25% or greater involuntary loss of income *(incarceration does not count as an involuntary loss of income in Georgia)*;
- Either party began receiving TANF benefits since the last order; and
- Unanticipated windfall of money.

Either parent has the right to request a modification review if the order is more than 36 months old. Upon receipt of the parties' information, the DCSS agent will run the child support worksheets and determine if a change in child support obligation is warranted according to our policies.

5. Are there any barriers, such as legal statutes, or policies, that prevent incarcerated parents from modifying their obligations?

Yes, the following prohibits incarcerated parents from modifying their applications:

- Staffon v. Staffon, 587 S.E.2d 630 (Ga. 2003); and
- Ga. Code Ann. § 19-6-15(f)(4)(D) (2013).

6. What is the process to ask for a modification of an existing child support order?

Parents must submit "Form RAF WEB/2-3 – Request for Review of Child Support Order" to request a modification review from their local office. An evaluation will be conducted to determine whether the amount of child support will increase, decrease, or remain unchanged.

A parent requesting a review is required to pay a $100 non-refundable review application fee when the review is complete, unless, the requesting parent is currently receiving TANF and/or Medicaid benefits, or if the parent can prove that his or her non-TANF gross income (before taxes) is $1,000 or less per month.

Parents are required to attach copies of their last two federal income tax returns and copies of their last three pay studs. Parents without tax returns or pay stubs are required to attach a separate sheet to Form RAF WEB/2-3 – Request for Review of Child Support Order" explaining why such information (i.e., tax returns, and pay studs) are unavailable.

Pursuant to the process, parents must complete and return the following forms:

- The Request for Review of Child Support Order,
- Personal/Financial Affidavit (*3 pages*),
- Confidential Information Form,
- Waiver of Personal Service, and
- Daycare Verification (*if applicable*).

A certified copy of a parent's order is also required. Failure to provide a certified copy may result in termination of the review.

7. Are there costs to request a modification?

A parent requesting a modification is required to pay a $100 non-refundable review application fee upon completion of the review, i.e., unless, the requesting parent is currently receiving TANF and/or Medicaid benefits, or if the parent can prove that his or her non-TANF gross income (*before taxes*) is $1,000 or less per month.

8. What is the process after a parent has asked for a modification? How long will it take?

When a review is requested, it may take up to 6 months to complete the process.

9. Is the modification process different if the other parent agrees to the modification? How?

Yes. A Settlement Negotiation can expedite the review if both parties are agreeable. If either parent is interested in modifying an order through the Settlement Negotiation process, they should complete the Settlement Negotiation Consent Form at http://dcss.dhs.georgia.gov/sites/dcss.dhs.georgia.gov/files/imported/DHR-OCSE/DHR-OCSE_Child_Support_Process/sett_neg_consent_form.pdf, and arrange for an appointment for an interview by contacting the DCSS Contact Center at 1-844-694-2347.

10. Does an incarcerated parent seeking a modification need to take any additional steps?

Georgia law does not recognize incarceration or lack of income due to incarceration as a valid reason for modification of a child support order. Therefore an incarcerated parent cannot seek a modification due to incarceration or a reduction of income due to incarceration; however an incarcerated parent may seek modification for any other qualifying reason.

11. Are there any special child support programs or services for incarcerated parents?

DCSS has a special operations unit called the Prison Paternity Unit for the purpose of assisting fathers in prison to establish legal paternity with their children. If the inmate is willing to participate voluntarily, the Prison Paternity Unit will assist in pursuing paternity establishment through administrative processes.

Although the Prison Paternity Unit is the only Georgia DCSS program to assist those currently incarcerated, the Fatherhood Program could assist those transitioning back into society after prison. Through the Fatherhood Program, the Division of Child Support Services has partnered with various government and community agencies to develop a comprehensive network of services to assist non-custodial parents with overcoming barriers to providing consistent child support payments.

DCSS Fatherhood Agents routinely make scheduled visits to the State Transition Centers for the purpose of presenting information to residents about the services of the Fatherhood Program and the Division of Child Support Services.

Fatherhood Agents provide informational presentations to residents on the following issues: child support, access and visitation, modifications, legitimizations, parental responsibility, and on whether the resident has a child support case or not. Fatherhood Agents also partner with local county Work Release Programs to provide DCSS services.

12. Are there any third-party services to assist incarcerated parents with child support questions, such as legal hotlines or other *pro se* resources?

Nothing provided by Georgia DCSS. Pro se persons may contact their local clerk of court for information on local resources or the Pro Bono Project of the State Bar of Georgia through the website at www.georgialegalaid.org .

13. Are there any child support materials targeted to incarcerated parents available?

No materials provided by Georgia DCSS.

14. Is there anything else parents should know about modification?

Upon release, a formerly incarcerated non-custodial parent can request to participate in the DCSS Fatherhood Program. The program works with non-custodial parents who owe child support through DCSS but are unable to pay due to barriers, such as: lack of a high school diploma, criminal record, no transportation, no driver's license, alcohol and substance abuse problems and mental health issues.

For information about the Georgia Fatherhood Services Program, non-custodial parents are encouraged to contact their local Child Support Services office at 1-844-MY-GA-DHS (1-844-694-2347) or see *Customer Online Services* at www.dcss.dhs.georgia.gov. Applications to the program may also be made online.

URL: http://dhr.georgia.gov/sites/dcss.dhs.georgia.gov/files/imported/DHR-OCSE/DHR-OCSE_About_OCSE/DCSS DHS Fatherhood fact sheet FY2010.pdf

The federal Office of Child Support Enforcement prepared this guide; however, your local child support agency can provide the most current information. This guide does not have any binding legal authority and does not constitute legal advice. You may wish to consult a lawyer before using the forms or information provided.

Information Regarding Review of Support Orders Which are Less Than 36 Months Old

You must justify a modification review on a "less than 36 month old Order" by proving a "substantial change in circumstances" that occurred since the last order or since the last modification was completed.

Examples of substantial changes for either party:

Diagnosis of a serious illness or an accident that impacts the parent's ability to work and is expected to last for over a year

Parent suffers a 25% or greater involuntary loss of income (e.g. parent's employer goes out of business)

Either party began receiving TANF benefits since the last order

Unanticipated windfall of money (e.g. party winning a large sum from the lottery, inheritance)

Examples which *are not* considered a substantial change in circumstances:

Divorce or custody order where the "custodian" agreed to "little or no" child support when the order was entered or last modified

Medical-Only Order issued by DCSS and CP later applies for full services

New financial obligations of either party, e.g. birth of another child, going into debt to purchase a house, etc

Under-employment, a job change or a voluntary decision to become self-employed

Parent is voluntarily working at a new job paying less than before

Parent is voluntarily working part-time when full-time work is available

Change in parent's income, marital status (either party) or additional expenses (e.g. new home, vehicle or recreational vehicle)

The facts described above are not all-inclusive but must convince the Georgia child support agency that these circumstances justify a "*less than 36 month review*". You must include documentation, not just statements, proving that the facts meet the description of a "substantial change in circumstances". **Note:** This agency is not responsible for proving your allegations.

If you proceed with requesting a review for possible modification of an order that is "*less than 36 months old*", you must include evidence and proof with the request. If additional information is needed for the review, you will be notified.

If the DCSS confirms that there is proof of a substantial change in circumstances, a full review will be scheduled.

If the DCSS finds that your situation does not meet the requirements of a "substantial change in circumstances", you will be notified that the request for review is being denied.

If you have any questions, you may call the Georgia Contact Center at 1-877-423-4746.

DIVISION OF CHILD SUPPORT SERVICES

Telephone: 1-877-423-4746 (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.

If you have any questions, please call 1-877-423-4746. 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: _____

DIVISION OF CHILD SUPPORT SERVICES
Telephone: 1-877-423-4746 (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.

If you have any questions, please call 1-877-423-4746. 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: _____

DIVISION OF CHILD SUPPORT SERVICES
SETTLEMENT NEGOTIATION PROCESS
CONSENT FORM

DCSS Case Number: _____ **(if known)**

Local Office: _____ **(if known)**

In signing this form, I give my consent and agree to participate in the Settlement Negotiation Process being offered by the Division of Child Support Services (DCSS).

- I declare that I have read the informational pamphlet and the consent form.
- I declare that my relationship with the other parent does not include a history of domestic violence.
- I understand that my participation is voluntary and that I will continue to receive services if I choose to withdraw as a participant of the Settlement Negotiation Process.
- I understand that I can withdraw as a participant at any time by notifying my local office Child Support Agent.
- I understand that my confidential, personal and financial information may be discussed with the other parent.
- I understand that participating in this process means that my Settlement Negotiation session may be observed by a DCSS supervisor or manager.
- I confirm that the Settlement Negotiation Pilot Process was explained to me, that all my questions were answered, and I was given necessary time to make a decision about my participation.

Thus, I accept and agree to:

- Undergo Settlement Negotiation as part of my requested services;
- Have my Settlement Negotiation session observed by an DCSS supervisor or manager, if my case is chosen for observation;
- Have my confidential, personal and financial information shared with the other parent; and
- Fill out any surveys about my participation in the Settlement Negotiation Process.

Participant Signature: _____ Date: ___/___/____

Section to be Completed by the Division of Child Support Services

I hereby certify that I explained the Settlement Negotiation Process to the participant and that I answered all the participant's questions. I also mentioned the right to withdraw at any time from participation in the Settlement Negotiation Process and that services would still be provided.

DCSS Staff Signature: _____ Date: ___/___/____

Please give a copy of this signed consent form to the participant and place the original in the case file.