



50 Douglas Dr., Ste. 100, Martinez, CA 94553-8507
Phone (925) 957-7300; Toll free: 1- (866) 244-5382
FAX: (925) 335-3636
E-mail: childsupport@dcss.co.contra-costa.ca.us
www.co.contra-costa.ca.us

Enclosed you will find the necessary forms to open a case with the Contra Costa County Department of Child Support Services. Mail or bring in your completed application and a copy of any court orders you have to:

Department of Child Support Services
50 Douglas Drive, Suite 100
Martinez, CA 94553

Once we have reviewed and opened your case, you will be notified of your assigned DCSS case number.

INFORMATION REGARDING THE APPLICATION FOR SUPPORT SERVICES PACKAGE

Our handling of this case depends upon the information you provide on these forms. Provide as much information as possible. If at all possible give both parents' Social Security Numbers . . . you can find it on pay stubs, tax returns, etc. Answer every question in full. If you do not know the answer, print "UNKNOWN." If the question does not apply, print "N/A."

There are several forms to read and complete. The package includes:

- Application for Support Services (CSS 2101)
- Information Regarding the Application for Support Services Package (CSS 2103)
- Child Care Verification (CSS 2105)
- Visitation Verification (CSS 2107)
- Instructions for Completing the Declaration of Support Payment History (CSS 2109)
- Declaration of Support Payment History (CSS 2109)
- Health Insurance Information (CSS 2111)
- Request for Support Services (CSS 2115)
- Child Support Domestic Violence Questionnaire (form 2142)
- Child Support Enforcement Program Notice (CS 196)
- Income and Expense Declaration (1285.50)
- Child Support Handbook (Pub. 160)

Instructions have been provided for the application form and the Declaration of Support Payment History.

Before you begin, please read the Child Support Handbook. This book will explain the services available through the local child support agency.

Also read the Child Support Enforcement Program Notice. This notice will explain your responsibility to the local child support agency and the local child support agency's responsibility to you.

Please complete all the forms in BLACK INK and PRINT clearly.

INSTRUCTIONS FOR COMPLETING
THE APPLICATION FOR SUPPORT SERVICES

SECTION I
IDENTIFYING INFORMATION

If the children named in the application have different noncustodial parents a separate application must be completed for each noncustodial parent. If you need additional space for any section, attach a separate piece of paper or use Section VII.

SECTION II
CHILD INFORMATION

List all the children of the parents named in Section I for whom support services are being requested. Complete the full name of each child; first name, middle name, last name, and suffix (Jr., Sr., III, etc.).

Ethnic Group - please indicate the group each person identifies with:

- | | | |
|------------------------------------|---------------|----------------------|
| (B) African American | (G) Guamanian | (L) Laotian |
| (I) American Indian/Alaskan Native | (U) Hawaiian | (A) Other Asian |
| (D) Cambodian | (H) Hispanic | (P) Pacific Islander |
| (W) Caucasian | (N) Indian | (S) Samoan |
| (C) Chinese | (J) Japanese | (V) Vietnamese |
| (F) Filipino | (K) Korean | (O) Other |

Also, use the above list to indicate the ethnic group that the custodial party and the noncustodial parent identify with in Sections III and V.

SECTION III
INFORMATION ABOUT THE CUSTODIAL PARTY

This section is about the person or party who has primary custody of the children. Complete the entire section. If you are the custodial party, be sure to give us a phone number where you may be reached during the day.

SECTION IV
IF YOU ARE NOT THE MOTHER OR THE FATHER OF THE CHILDREN

Complete this section if you are an aunt, uncle, grandmother, unrelated caretaker, etc. to the children. You will need to complete two Applications for Service, one for the mother as a noncustodial parent and one for the father as a noncustodial parent. Be sure you have completed Section II and the information is about you.

SECTION V
INFORMATION ABOUT THE NONCUSTODIAL PARENT

This section is very long and may require you to look through old papers to find some of the information requested. The more information we have in this section the better we will be able to serve you.

Section V, page 3 - if at all possible, provide the noncustodial parent's Social Security Number or numbers. If you do not know the exact date of birth, provide the approximate age.

Section V, page 4 - provide any and all financial information about the noncustodial parent. Attach additional page(s) as needed or use Section VII, page 5.

SECTION VI
MARRIAGE/ORDER INFORMATION

Complete this section whether or not YOU were married to the other parent. Answer each question as it relates to the mother and the father of the children. If you and/or the other parent were represented by an attorney for divorce, custody or guardianship, please list the attorney's name and address.

SECTION VII
COMMENTS

You may use this section as extra space, if needed, or add any additional information you think might help us establish or enforce an order for the children. You may include information about the other person's temper; whether they own rifles or handguns; if they have made threats against you or the children, etc.

SECTION VIII
SIGNATURE PAGE

Read this page very carefully. We will not be able to open this case without your signature.

Your signature indicates that you have answered the questions on the application to the best of your ability and that you want to open this case. It also indicates that you have read the information provided above the signature line; that you understand your responsibility for providing information to the local child support agency; and that the local child support attorneys or Attorney General or any of their representatives are not your attorney or the children's attorney.

ADDITIONAL FORMS TO BE COMPLETED

1. Request for Support Services - complete, sign and date.
2. Child Care Verification - take form to child care provider to complete and sign. This helps the Local Child Support Agency compute child support amounts.
3. Visitation Verification - complete and sign. This also helps the local child support agency compute child support amounts.
4. Health Insurance Information - complete to the best of your knowledge.
5. Declaration of Support Payment History - complete, sign and date. Separate instructions are included for this form.
6. Child Support Domestic Violence Questionnaire - complete, sign and date.
7. Income and Expense Declaration - complete, sign and date.

PLEASE PROVIDE COMPLETED FORMS
TO
YOUR LOCAL CHILD SUPPORT AGENCY

CHILD SUPPORT SERVICES PROGRAM NOTICE

WHAT CHILD SUPPORT CAN DO FOR YOU:

All children have the right to be supported by both parents. Any person, including a noncustodial parent, whether or not he or she receives public assistance, can apply for support services. Some of the available services are as follows:

- locating the parent(s) for support enforcement purposes;
- establishing paternity (legal fatherhood);
- establishing a child and/or medical support (health insurance) order;
- enforcing a child and/or medical support order;
- modifying an existing court order for child and/or medical support;
- enforcing a spousal support order in conjunction with a child support order;
- collecting and distributing support payments.

CUSTODY AND VISITATION SERVICES ARE NOT PROVIDED

THE LOCAL CHILD SUPPORT AGENCY PROVIDES SERVICES ON BEHALF OF THE STATE OF CALIFORNIA. THEY DO NOT REPRESENT YOU AND ARE NOT YOUR ATTORNEY. BECAUSE YOU ARE NOT THEIR CLIENT, THE INFORMATION YOU PROVIDE IS NOT CONFIDENTIAL UNDER ATTORNEY/CLIENT PRIVILEGE.

SOCIAL SECURITY NUMBER DISCLOSURE

The information in your case may be discussed or given to the State, the Department of Child Support Services, other public agencies that can legally receive such information, and to the other parent or his/her attorney to the extent required by law. The local child support agency is required, under Section 466(a)(13) of the Social Security Act, to include in child support records the Social Security Number of any individual who is subject to a divorce decree, support order or paternity determination or acknowledgment. Social Security number information is mandatory and will be kept on file at the local child support agency to locate individuals for the purpose of establishing, modifying and enforcing child support obligations. Enrolling a child in health insurance may require the release of the child's Social Security Number and mailing address to the other parent's employer or the release of the child's Social Security Number to the other parent.

COOPERATION WITH CHILD SUPPORT

When you request services, you must cooperate with the local child support agency by providing any information or documents needed to establish paternity and/or locate the other parent and to get support payments for your child. Once the services of the local child support agency have been requested, the local child support agency will determine the appropriate actions to take. All support payments must be turned over to the local child support agency.

When you apply for, or receive, support services, you are responsible for promptly informing the local child support agency of any changes in circumstance or information. Some examples are:

- child leaves the home;
- telephone number or address changes (including a move to another State, County or Country);
- stopping public assistance (CalWORKs);
- name change;
- initiation of divorce or legal proceedings;
- information regarding the noncustodial parent;
- direct receipt of any child, spousal, or family support payment.

YOUR RIGHTS

You have the right to seek legal advice from a private attorney or legal aid group at your own expense. If you hire an attorney, you must tell the local child support agency. For free legal assistance, you may contact the Superior Court's Office of the Family Law Facilitator, or free legal services maybe available at the local legal services office.

If you have a support order in the State of California, you can ask the local child support agency to review your support order to determine if the amount of support should be changed based on statewide guidelines. If the amount of support does not meet guidelines for change, the local child support agency must give you or the other parent, upon request, information on how to get the forms to request the court to change the amount of support ordered. The local child support agency must also tell you of the initial date, time and purpose of every hearing for paternity or support. You also have the right to read the county clerk's file, unless that information is legally prohibited by confidentiality requirements.

You or the other parent may raise issues concerning support, custody, visitation, and restraining orders. The local child support agency will give you copies of the most recent order entered in your case. You can go to court to enforce your support order, but you must give the local child support agency advance notice that you intend to file your own enforcement action. If the local child support agency does not respond to your notice within 30 days or if the local child support agency tells you that you can proceed, you can then file your own enforcement action as long as all support is payable through the local child support agency.

The local child support agency must have the permission of a non-public assistance recipient before filing a stipulation affecting the support order in which that person is named as a party. The local child support agency can not, without a public assistance recipient's consent, enter into a stipulation that will decrease the amount of over due support when the recipient is owed over due support that is more than the unreimbursed public assistance.

The payments received by the local child support agency are applied in the following order*:

1. Current monthly support;
2. Interest;
3. Past due support - first non-welfare arrears, then welfare arrears; and
4. Future obligations.

*Federal income tax refunds owed to the noncustodial parent can be intercepted by the local child support agency, and are applied differently than other payments received by the local child support agency. By Federal law, this money cannot be applied to current child/spousal/family/medical support obligations. It must be applied to the past due child support. If a custodial parent has received public assistance, including Medi-Cal, the past due child support owed to the State/County will be paid first.

CALIFORNIA DOES NOT CHARGE AN APPLICATION FEE AND DOES NOT CHARGE FOR THE CHILD SUPPORT SERVICES PROVIDED TO APPLICANTS. HOWEVER, SOME STATES DO CHARGE A FEE FOR SERVICES. IF YOUR CASE INVOLVES ONE OF THOSE STATES, THEY MAY DEDUCT THE FEE FROM THE SUPPORT PAYMENTS, OR ADD IT TO THE BALANCE THAT IS OWED. IN ADDITION, IN SOME SITUATIONS, COST FOR GENETIC TESTS MAY BE CHARGED.

NOTICE OF COLLECTIONS AND DISTRIBUTION

You will get a Notice of Collections and Distribution of support payments every month from the local child support agency. The Notice will show you all support that was collected and paid out during the time period shown on the Notice. You will not receive a Notice of Collections and Distribution in a month that no support was received or paid out.

MEDICAL SUPPORT AND MEDI-CAL

Every child is entitled to a court order that requires one or both parents to provide health insurance if health insurance is available at reasonable cost. In general, the cost of health insurance is reasonable if it is employment-related group health insurance or other group health insurance. However, in determining reasonable cost, the court will also consider the actual cost to the parent(s) of the health insurance.

The local child support agency will ask the court to establish or modify a child support order to require the parent(s) to provide health insurance if it is available at reasonable cost. The custodial parent may also request that the local child support agency modify the child support order to include a provision for health insurance. This may affect the amount of the monthly child support obligations. If the noncustodial parent is ordered to provide health insurance coverage, the local child support agency will contact the noncustodial parent and his or her employer, if necessary, to secure health insurance for the child. After the local child support agency receives the policy information, a copy will be given to the custodial parent.

Having private health insurance coverage does not prevent you from having Medi-Cal coverage. If you receive Medi-Cal and have individual or group health private coverage (including dental or vision coverage), you are required by Federal and State law to tell your county CalWORKs department, your health care provider, and/or the local child support agency. Failure to provide this information is a misdemeanor. You must report to your CalWORKs eligibility worker and/or local child support agency within ten days when your private health coverage changes or stops. You must also tell your CalWORKs eligibility worker and/or the local child support agency about any court order regarding health insurance.

If you are only receiving Medi-Cal benefits, you must cooperate in establishing paternity and obtaining medical support as a condition of continued eligibility for Medi-Cal benefits for you, unless you have filed and the County CalWORKs department has approved a claim of "good cause" (CA 51) for not cooperating. Your children will still be eligible for Medi-Cal. Also, all child support services will be given, unless you tell the local child support agency that you do not want services that are unrelated to obtaining medical support and establishing paternity. Obtaining medical support may reduce the amount of child support you receive. In cases where both parents are in the home, the local child support agency will establish paternity only.

Under Federal law [42 U.S.C. Section 1396A (25)], health insurance belonging to a Medi-Cal recipient in a child or medical support enforcement case is used as follows:

The service provider will bill Medi-Cal. Medi-Cal will pay the service provider. Then Medi-Cal will seek repayment from the other health coverage. You are not responsible for any insurance cost-sharing amount (co-insurance, co-payment or deductible) unless a Medi-Cal co-payment or share of cost must be met. The provider may bill you for the service if you do not cooperate in identifying your private health insurance. If your other health insurance is a Prepaid Health Plan (PHP) or a health maintenance organization (HMO), you must use the plan facilities for regular medical care. Except for out-of-area service or emergency care, Medi-Cal will not pay for services rendered by a provider not associated with your PHP/HMO. Out-of-area services or emergency care should be billed to the PHP/HMO.

FOR MORE INFORMATION ON CHILD SUPPORT SERVICES PLEASE REFER TO YOUR CHILD SUPPORT HANDBOOK

NONDISCRIMINATION STATEMENT

It is the policy of the State of California to ensure that all individuals are treated equally and that no person shall, on the basis of ethnic group identification, race, color, national origin, political affiliation or belief, religion, sex, age or disability be excluded from participation in, denied the benefits of any program or service, or otherwise be subjected to treatment that is different than that provided to others.

Each local child support agency has a designated Civil Rights Coordinator. Any applicant/recipient who feels they have been subjected to discriminatory treatment may file a complaint of discrimination by first contacting the local child support agency's designated Civil Rights Coordinator or by writing to the California Department of Child Support Services, Attn: Human Services Section, Civil Rights Office, P.O. Box 419064, Rancho Cordova, CA 95741-9064 or telephone (916) 464-5200.

APPLICATION FOR SUPPORT SERVICES

Page 1 of 5

SECTION I: IDENTIFYING

YOUR NAME (First, Middle, Last, Suffix)	<input type="checkbox"/> CUSTODIAL PARTY <input type="checkbox"/> NONCUSTODIAL PARENT
CHILD(REN)'S MOTHER'S NAME (First, Middle, Last, Suffix)	
CHILD(REN)'S FATHER'S NAME (First, Middle, Last, Suffix)	

SECTION II: CHILD(REN) OF THE PARENTS NAMED ABOVE

List the unmarried dependent child(ren) of the parents named above for whom you are requesting support services. If the mother is pregnant with the child of the father named above, list "UNBORN" as the child's name and the expected due date as the BIRTH DATE.

CHILD'S FULL NAME and ANY OTHER NAMES USED (include Nicknames) First, Middle, Last, Suffix	SEX	ETHNIC GROUP <small>See Instructions</small>	BIRTH DATE (MM/DD/CCYY)	SOCIAL SECURITY NUMBER	PLACE OF BIRTH (City, State & Country)	
1.	<input type="checkbox"/> M					
	<input type="checkbox"/> F					
Is there a court order for support?				<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN
2.	<input type="checkbox"/> M					
	<input type="checkbox"/> F					
Is there a court order for support?				<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN
3.	<input type="checkbox"/> M					
	<input type="checkbox"/> F					
Is there a court order for support?				<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN
4.	<input type="checkbox"/> M					
	<input type="checkbox"/> F					
Is there a court order for support?				<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN
5.	<input type="checkbox"/> M					
	<input type="checkbox"/> F					
Is there a court order for support?				<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN
6.	<input type="checkbox"/> M					
	<input type="checkbox"/> F					
Is there a court order for support?				<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN
7.	<input type="checkbox"/> M					
	<input type="checkbox"/> F					
Is there a court order for support?				<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN
8.	<input type="checkbox"/> M					
	<input type="checkbox"/> F					
Is there a court order for support?				<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN

If child(ren)'s address is different than yours, please complete the information below:(attach additional page if necessary)

CHILD'S LAST AND FIRST NAME
ADDRESS: Street, Apt. or Unit No.
City, State, Zip Code
CHILD'S LAST AND FIRST NAME
ADDRESS: Street, Apt. or Unit No.
City, State, Zip Code

SECTION III: COMPLETE THE FOLLOWING INFORMATION ABOUT THE CUSTODIAL PARTY

NOTE: The custodial party is the person or party who has primary custody of the children.

FULL NAME (First, Middle, Last)		RELATIONSHIP TO CHILDREN (Mother, Father, Grandparent, Aunt, Uncle, Cousin, Friend, etc.)	
MAIDEN NAME OR OTHER NAME(S) USED			
SOCIAL SECURITY NUMBER	BIRTH DATE (MM/DD/CCYY)	PLACE OF BIRTH (City, State & Country)	
ETHNIC GROUP (see instructions)	SEX Check one: <input type="checkbox"/> M <input type="checkbox"/> F	COLOR OF HAIR	COLOR OF EYES
WEIGHT	HEIGHT	DRIVER'S LICENSE NO.	STATE
PRIMARY LANGUAGE SPOKEN IN HOME Check one: <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> CHINESE <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> CAMBODIAN <input type="checkbox"/> LAOTIAN <input type="checkbox"/> OTHER _____			
Can the Custodial Party read and understand English? Check one: <input type="checkbox"/> YES <input type="checkbox"/> NO			

HOME ADDRESS: Street, Apt. or Unit No.

City, State, Zip Code	TELEPHONE NO. (include area code)
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MAILING ADDRESS: Street, Apt. or Unit No. or P.O. Box (if different from home address)

City, State, Zip Code	MESSAGE TELEPHONE NO. (include area code)
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List other child(ren) of the custodial party different from children listed in Section II

FULL NAME (First, Middle, Last)	SEX	BIRTHDATE OR APPROXIMATE AGE
1.		
2.		
3.		

EMPLOYER	TELEPHONE NO. (include area code)
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ADDRESS: Street, Apt. or Unit No.

City, State, Zip Code

OCCUPATION/JOB TITLE	WAGES \$	PAID: <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> SEMI-MONTHLY <input type="checkbox"/> MONTHLY
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Is Health Insurance available for the child(ren) through this employer? YES NO UNKNOWN

Is Dental Insurance available for the child(ren) through this employer? YES NO UNKNOWN

Is Vision Insurance available for the child(ren) through this employer? YES NO UNKNOWN

If you answered YES to any of these questions, please complete the HEALTH INSURANCE INFORMATION (OCS 2111) form included in this package.

**** ATTACH A COPY OF YOUR MOST RECENT PAYCHECK STUB ONLY IF YOU ARE THE PARENT OF THE CHILD(REN) ****

Have the child(ren) ever received public assistance/welfare or Child Support Services in another state or county? YES NO UNKNOWN

If YES, complete the following: (Attach additional page(s) if needed.)

STATE	COUNTY	DATES: (Month, Day, Year) From:	To:
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SECTION IV: COMPLETE IF YOU ARE NOT THE MOTHER OR THE FATHER OF THE CHILDREN

CHILD(REN)'S MOTHER'S NAME (First, Middle, Last, Suffix)	YOUR RELATIONSHIP TO THE CHILD(REN)'S MOTHER
MOTHER'S MAIDEN NAME OR OTHER NAME(S) USED	
CHILD(REN)'S FATHER'S NAME (First, Middle, Last, Suffix)	YOUR RELATIONSHIP TO THE CHILD(REN)'S FATHER
FATHER'S OTHER NAME(S) USED	

SECTION V: INFORMATION ABOUT THE NONCUSTODIAL PARENT(S)

FULL NAME (First, Middle, Last, Suffix)	RELATIONSHIP TO CHILD(REN) <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER
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MAIDEN NAME OR OTHER NAME(S) USED

SOCIAL SECURITY NUMBER(S) (list more than one if necessary)

BIRTH DATE (MM/DD/CCYY)	APPROXIMATE AGE	PLACE OF BIRTH (City, State & Country)	
ETHNIC GROUP (see instructions)	SEX Check one: <input type="checkbox"/> M <input type="checkbox"/> F	COLOR OF HAIR	COLOR OF EYES
WEIGHT	HEIGHT	DRIVER'S LICENSE NO.	STATE

SCARS, MARKS, TATTOOS

PRIMARY LANGUAGE SPOKEN IN HOME

Check one: ENGLISH SPANISH CHINESE VIETNAMESE CAMBODIAN LAOTIAN OTHER _____

Can the Noncustodial Parent read and understand English? Check one: YES NO

CURRENT HOME ADDRESS: Street, Apt. or Unit No. DATE

City, State, Zip Code TELEPHONE NO. (include area code)

LAST KNOWN ADDRESS: Street, Apt. or Unit No. (If different from above) DATE

City, State, Zip Code TELEPHONE NO. (include area code)

MAILING ADDRESS: Street, Apt. or Unit No. or P.O. Box (if different from home address) DATE

City, State, Zip Code MESSAGE TELEPHONE NO. (include area code)

Has the Noncustodial Parent ever been arrested? YES NO If YES, when (date):

WHERE (City or County and State)	WHY
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NONCUSTODIAL PARENT'S CURRENT SPOUSE'S NAME (First, Middle, Last)

NONCUSTODIAL PARENT'S MOTHER'S MAIDEN NAME (First, Middle, Last)	LOCATION OF MOTHER'S RESIDENCE (County & State)
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MOTHER'S ADDRESS: Street, Apt. or Unit No., City, State, Zip Code

NONCUSTODIAL PARENT'S FATHER'S NAME (First, Middle, Last)	LOCATION OF FATHER'S RESIDENCE (County & State)
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FATHER'S ADDRESS: Street, Apt. or Unit No., City, State, Zip Code

List other child(ren) of the noncustodial parent different from children listed in Section II

FULL NAME (First, Middle, Last)	SEX	BIRTHDATE OR APPROXIMATE AGE
1.		
2.		
3.		

Is the noncustodial parent currently or ever been in the Military? YES NO If YES, complete information on the next line.

BRANCH (Army, Air Force, Marines, Coast Guard)	RANK	DATES (Month, Year) FROM TO
--	------	---

APPLICATION ID:

SECTION V: INFORMATION ABOUT THE NONCUSTODIAL PARENT(S) (Continued)

CURRENT EMPLOYER	TELEPHONE NO. (include area code)
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ADDRESS: Street, Apt. or Unit No.

City, State, Zip Code

OCCUPATION/JOB TITLE

Is Health Insurance available for the child(ren) through this employer? YES NO UNKNOWN

Is Dental Insurance available for the child(ren) through this employer? YES NO UNKNOWN

Is Vision Insurance available for the child(ren) through this employer? YES NO UNKNOWN

If you answered YES to any of these questions, please complete the HEALTH INSURANCE INFORMATION (OCS 2111) form included in this package.

**** ATTACH A COPY OF YOUR MOST RECENT PAYCHECK STUB IF YOU ARE THE NONCUSTODIAL PARENT****
 IF YOU ARE THE CUSTODIAL PARTY AND HAVE A COPY OF THE NONCUSTODIAL PARENT'S PAY STUB, PLEASE ATTACH IT.

UNION NAME	LOCAL NO.
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ADDRESS: Street, Apt. or Unit No.

City, State, Zip Code

IF SELF-EMPLOYED	NAME OF BUSINESS	TYPE OF BUSINESS
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PREVIOUS OR ADDITIONAL EMPLOYER	IF PREVIOUS EMPLOYER, DATES (Month, Year)
	FROM TO

ADDRESS: Street, Apt. or Unit No.

City, State, Zip Code

TELEPHONE NO. (include area code)

OCCUPATION/JOB TITLE	UNION NAME OR LOCAL NO.
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Does the noncustodial parent own a car, boat, motorcycle, trailer, etc? YES NO UNKNOWN If YES, complete the following:

VEHICLE TYPE	1	2	3	4
MAKE				
MODEL / YEAR				
COLOR				
LICENSE NO./STATE				

Does the noncustodial parent own any real estate? YES NO UNKNOWN If YES, complete the following:

LOCATION (City/State)	1	2
ADDRESS (Street, Apt. or Unit No.)		
TYPE (Residential, Commercial, etc.)		

Does the noncustodial parent have any bank accounts? YES NO UNKNOWN If YES, complete the following:

BANK/CREDIT UNION	1	2	3	4
BRANCH				
ADDRESS				
ACCOUNT NO.				
TYPE OF ACCOUNT	<input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS	<input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS	<input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS	<input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS

Does the noncustodial parent have any other financial assets, stocks, bonds, etc.? YES NO UNKNOWN If YES, complete the following:

LOCATION	1	2	3	4
TYPE				

SECTION VI: MARRIAGE & COURT ORDER INFORMATION

Were the mother and father of the child(ren) married to each other? YES NO UNKNOWN If YES, complete the following:

DATE OF MARRIAGE	DATE OF SEPARATION	DATE OF DIVORCE	DIVORCE CASE NO.
------------------	--------------------	-----------------	------------------

LOCATION OF MARRIAGE (City, County, State & Country)

LOCATION OF DIVORCE (City, County, State & Country)

Is there a support order? YES NO UNKNOWN If YES, complete the following:

DATE ORDER FILED	COURT ORDER NO.
------------------	-----------------

WHERE ORDER WAS FILED (City, County, State & Country)

Has an order for paternity been established? YES NO UNKNOWN If YES, complete the following:

DATE ORDER FILED	COURT ORDER NO.
------------------	-----------------

WHERE ORDER WAS FILED (City, County, State & Country)

If you are not the mother or the father of the child(ren), is there a court order granting custody to you? YES NO UNKNOWN
If YES, complete the following:

DATE ORDER FILED	COURT ORDER NO.
------------------	-----------------

WHERE ORDER WAS FILED (City, County, State & Country)

CUSTODIAL PARTY'S ATTORNEY'S NAME	TELEPHONE NO. (include area code)
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ADDRESS: Street, Apt. or Unit No.

City, State, Zip Code

NONCUSTODIAL PARENT'S ATTORNEY'S NAME	TELEPHONE NO. (include area code)
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ADDRESS: Street, Apt. or Unit No.

City, State, Zip Code

COURT ACTION PENDING? YES NO DOCKET # _____ COUNTY, STATE _____

SECTION VII: COMMENTS

PROVIDE ADDITIONAL COMMENTS/INFORMATION HERE

SECTION VIII (MUST BE COMPLETED)

Read carefully before signing below. Your signature is required in order for us to open a case for you.

I declare under penalty of perjury that the information I have provided on this application is true to the best of my knowledge and belief.

SIGNATURE OF APPLICANT

DATE: _____

FOR OFFICE USE ONLY

APPLICATION ID:	DATE MAILED:	DATE RECEIVED:
DATE REQUESTED:		

REQUEST FOR SUPPORT SERVICES

INSTRUCTIONS: Read carefully before signing each of the areas below. Your signature is required in order for us to open a case for you.

I request the services of the local child support agency to assist in my efforts to locate the noncustodial parent, establish paternity and/or secure support for the children listed in Section II.

I am applying for these services under the Child Support Enforcement Program under Title IV-D of the Social Security Act.

I will notify the Local Child Support Agency immediately of any of the following events:

- When each child marries, reaches age 19 or reaches age 18 and is not a full-time student, whichever occurs first.
- Any change in my residence address, mailing address, or telephone number.
- Any change in my employer, including name, address and telephone number.
- Any change in my income.
- Any change in the status, cost or availability of health insurance coverage.
- Any information regarding the whereabouts of the other parent(s).
- When the parent(s) move back in together with the children.
- Any change in the custody of the children.
- Any change in child care.

I am aware that the local child support agency and the Attorney General do not represent me, the other parent, or the children who are the subject of this case. No attorney-client relationship exists between the local child support agency or the Attorney General, and myself, the other parent, or the children. No attorney-client relationship will arise if the local child support agency or the Attorney General provides the support services I have requested.

I declare under penalty of perjury that I have read, understand and agree to all of the terms specified above.

SIGNATURE: _____ DATE: _____

Your signature below acknowledges that you are aware that any amounts overpaid to you may not be deducted from future support payments sent to you unless you consent in writing at the time, which consent may be revoked at any time. However if you do not consent to repay the overpayment to the county by a deduction from future support, the local child support agency is authorized to use the collection of the last unassigned arrearage payment to repay the overpayment.

SUPERIOR COURT VISITATION PERCENTAGES

DEFINITIONS:

Standard weekend: Friday evening through Sunday evening
 Long weekend: Friday evening through Monday morning
 Extended weekend: Thursday evening through Monday morning
 Evening, not overnight: .25 of one day
 Evening, overnight: .5 of one day

VISITATION SCHEDULE	TOTAL DAYS PER YEAR	PERCENTAGE
1 std weekend/month (2 x 12)	24	6
1 long weekend/month (2.5 x 12)	30	8
1 extended weekend/month (3.5 x 12)	42	12
1 evening/week, not overnight (.25 x 52)	13	4
Alternate weekly overnight (.5 x 26)	13	4
1 evening week, overnight (.5 x 52)	26	7
Alternate std weekends (2 x 26)	52	14
Alternate long weekends (2.5 x 26)	65	18
Alternate extended weekends (3.5 x 26)	91	25
Alternate std weekends + 1 evening alternate weeks (2 x 26 + .25 x 26)	59	16
Alternate long weekends + 1 evening alternate weeks (2.5 x 26 + .25 x 26)	72	20
Alternate std weekends + one evening per week (2 x 26 + .25 x 26)	65	18
Alternate long weekends + one evening/week (2.5 x 26 + .25 x 52)	78	21
Alternate std weekends + 1 overnight alternate week (2 x 26 + .5 x 26)	65	18

DCSS#

Alternate long weekends + 1 overnight alternate week (2.5 x 26 +.5 x26)	78	21
Alternate extended weekends + 1 overnight alternate week (3.5 x 26 +.5 x26)	104	28
Alternate std weekends + 1/2 summer and holidays (2 x 26 +42 -6 +12.5 -2)	98	27
Alternate long weekends + 1/2 summer and holidays (2.5 x26 +42 -7.5 + 12.5 -2.5)	110	30
Alternate extended weekends + 1/2 summer and holidays (3.5 x 26 +42 -10 + 12.5 -3.5)	132	36
Alternate std weekends + 1 month summer and 1/2 holidays (2 x 26 + 30 -4 +12.5 -2)	88	24
Alternate long weekends + 1 month summer and 1/2 holidays (2.5 x 26 + 30 -5 + 12.5 -2.5)	100	27
Alternate extended weekends + 1 month summer and 1/2 holidays (3.5 x 26 +30 -7 + 12.5 -3.5)	123	34
Alternate std weekends + 1 evening per week + 1 month summer and 1/2 holidays (2 x26 +25 x52 + 30 -4 +12.5 -2)	101	28
Alternate long weekends + 1 evening per week + 1 month summer and 1/2 holidays (2.5 x26 + 25 x52 +30 -5 +12.5 -2.5)	113	31
Alternate extended weekends + 1 evening per week + 1 month summer and 1/2 holidays (3.5 x26 +25 x52 +30 -7 +12.5 -3.5)	136	41

SPECIAL ADDITIONS AND SUBTRACTIONS

One half of the summer	42	11.5
------------------------	----	------

Note: You must SUBTRACT the weekends used in the initial calculation. Therefore, the appropriate adjustments are:

Alternate std weekends - 6 days	36	10
Alternate long weekends - 7.5 days	35	10
Alternate extended weekends - 10 days	32	9
Alternate holidays (Christmas 14, Easter 7, Thanksgiving 4)	12.5	3

VISITATION VERIFICATION

NAME OF PERSON COMPLETING FORM: _____

I am the Custodial Party Noncustodial Parent

Part 1. ACTUAL VISITATION BY THE NONCUSTODIAL PARENT

INSTRUCTIONS: Complete the visitation history for the past 12 months by filling in the number of hours per month the noncustodial parent actually visited with the children.

Example: If the last 12 months are June of 2000 through May of 2001, you will complete June through December on the left side of the chart below. You would put 2000 for the year. Then you would complete the right side of the chart with January through May and enter 2001 for the year.

YEAR _____

YEAR _____

MONTH	NO. OF HOURS PER MONTH	MONTH	NO. OF HOURS PER MONTH
January		January	
February		February	
March		March	
April		April	
May		May	
June		June	
July		July	
August		August	
September		September	
October		October	
November		November	
December		December	
TOTAL		TOTAL	

Part 2. SHARED CUSTODY/VISITATION ARRANGEMENTS

CHECK ONE: Shared Custody Visitation Only None

Please describe custody/visitation arrangements:

Visitation Hours: From (specify day of the week) _____ at (specify time) _____ a.m./p.m. (Circle One)

To (specify day of the week) _____ at (specify time) _____ a.m./p.m. (Circle One)

Overnight Visitation? Yes No

Is this custody/visitation arrangement court-ordered? Yes No

I declare to the best of my knowledge and belief that the above information is true and correct. I am aware that this may be provided to the other parent for their verification and that either party may be required to provide documentation.

Signature: _____

Date: _____

PETITIONER/PLAINTIFF: RESPONDENT/DEFENDANT: OTHER PARENT:	CASE NUMBER:
---	--------------

PAYMENT HISTORY FOR (check one):

- Child
 Spousal
 Family
 Medical
 Unreimbursed child care
 Unreimbursed medical
 Other (specify):

YEAR _____ YEAR _____ YEAR _____

	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						
TOTAL						

YEAR _____ YEAR _____ YEAR _____

	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						
TOTAL						

PAYMENT HISTORY ATTACHMENT
 (Family Law -- Governmental -- Uniform Parentage Act)

INSTRUCTIONS FOR COMPLETING THE
DECLARATION OF SUPPORT PAYMENT HISTORY

The reverse of this page is your declaration of the support payment history for your case. You are asked to complete a month-by-month, year-by-year breakdown of the amounts of support that were due (ordered by the court) and the amount of each payment that was made. These figures will help determine the amount of past due support owed, if any.

You must complete a separate page (or pages) for child support, spousal support, family support, medical support, unreimbursed medical expenses, and other types of support not listed. DO NOT combine child support and spousal support unless your court order combines the two support payments into a "family" support order.

In the Amount Ordered column, fill in the amount of support that became due each month since your court order began. If there has been a change in your court order, make sure each month reflects the correct amount of support due.

In the Amount Paid column, indicate a dollar amount of support paid in that month. If more than one payment was made in a given month, put the total dollar amount of support paid. Put the dollar amounts next to the month in which the payment was actually made, and not the month or months which those payments were intended to cover. You may attach additional sheets as necessary.

Be aware that this declaration is not confidential and may be given to the other parent in your case for review. If there is a disagreement regarding the payment history, the parties may be required to present proof of payments in the form of canceled checks, receipts, etc.

Complete this Declaration neatly and correctly to make sure there is no mistake nor confusion as to the amounts of past due support owed, if any.

INSTRUCTIONS FOR COMPLETING PAYMENT RECORD

You must complete a separate Payment History Attachment form for each type of support paid. Enter the year, list the amount ordered, and the amount paid for each month during that year. If the amounts repeat in a column, you can use an arrow as shown in the example below. Add the amounts in each column to get the yearly totals. Enter the totals at the bottom.

Attach additional sheets and supporting documents (bills, receipts, and other proof of expense) as necessary.

Child

	Year <u>2000</u>		Year <u>2001</u>	
	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID
January	100	0	100	100
February		↓		0
March		↓		↓
April		100		100
May		100		0
June		100		↓
July		0		↓
August		↓		100
September		↓		100
October		100		0
November	↓	↓	↓	↓
December	↓	↓	↓	↓
TOTAL	1,200	600	1,200	400

Spousal

	AMOUNT ORDERED	AMOUNT PAID
January	100	0
February		↓
March		↓
April		100
May		100
June		100
July		0
August		↓
September		↓
October		100
November	↓	↓
December	↓	↓
TOTAL	1,200	600

UNREIMBURSED CHILD CARE, MEDICAL, OR OTHER EXPENSES:

You must complete a separate Payment History Attachment form for each type of unreimbursed expense. If you have more than one bill, receipt and other proof of expense per month use an additional declaration page (form MC-031) or separate page. 1.) Itemize each expense; 2.) attach proof of bill or payment; 3.) mark each bill or payment with an Exhibit # _____; 4.) group the bills, receipts, and other proof of expense in chronological order for each month; and 5.) enter the total bills, receipts, and other proof of expense for each month. If your court order did not state a specific due date for reimbursement, then include that amount in the month that the expense was incurred.

Unreimbursed child care expenses

	Year <u>2001</u>	
	AMOUNT ORDERED	AMOUNT PAID
January	50% (\$200)	0
February	50% (\$200)	100
March	50% (\$200)	0
April	50% (\$200)	50
May		
June		
July		
August		
September		
October		
November		
December		
TOTAL	\$400	150

Unreimbursed medical expenses

	Year <u>2001</u>	
	AMOUNT ORDERED	AMOUNT PAID
January	50% (\$200)	0
February		
March	50% (\$200)	0
April	50% (\$75)	0
May		
June		
July		
August		
September		
October		
November		
December		
TOTAL	\$237.50	0

Form MC-031

Petitioner/Plaintiff Defendant/Respondent	CASE NUMBER
I request reimbursement for 50% of these expenses, which are supported by copies of bills, receipts, and other proof of expense.	
01/04/01 Dr. Adams	\$45.00 Exhibit A
01/08/01 Dr. Lee, D.D.S.	\$155.00 Exhibit B
02/15/01 AB X-ray Inc.	\$200.00 Exhibit C
04/26/01 Kids Therapy	\$75.00 Exhibit D
Child care expenses: 01/02 ABC School 50% (200) 02/02 ABC School 50% (200) 03/02 ABC School 50% (200) 04/02 ABC School 50% (200) — Exhibit E	
I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.	
----- (TYPE OR PRINT NAME)	----- (SIGNATURE OF DECLARANT)
Form MC-031 ATTACHED DECLARATION	

YOU MUST PROVIDE THE INFORMATION REQUESTED BELOW AND CHECK ALL BOXES WHICH APPLY TO YOUR SITUATION.

I. A. [] List all counties/states where your children have received welfare (cash public assistance payments) and the date when you received aid.

LOCATION		DATES	
COUNTY	STATE	FROM	THRU

OR B. [] My children have not received public assistance (welfare) in any other county/state to the best of my knowledge.

II. A. [] Please provide this office with a copy of your divorce papers and/or any order from a court for child support or establishment of parentage. Include all modifications (change to the court order).

OR B. [] If you cannot obtain a copy of the requested documents, please provide the following information:

Date of Order: _____

City and State that issued order: _____

If you had an attorney help you obtain the order(s), please provide the attorney's name and address below:

OR C. [] To the best of my knowledge, there is not a court order for support/paternity.

III. [] The balance owing under the court order is _____ (through the present amount due).
 YOU MUST COMPLETE THE ATTACHED PAYMENT HISTORY FORM.

I declare under penalty of perjury under the laws of the State of California or the state of my residence that the foregoing is true and correct.

 DATE

 SIGNATURE

 DCSS#

 PRINT NAME

PATERNITY QUESTIONNAIRE

Page 1 of 4

A separate paternity questionnaire must be completed for each child that paternity must be establishedChild's Name: _____
Firs Middl Last Suffi**SECTION I: (Complete and then follow the instructions listed after question #5.)**

1. Is there a court order establishing the noncustodial parent's parentage of child? [] Yes [] N
2. Is the noncustodial parent willing to agree to a court order of parentage? [] Yes [] N
3. When your child was born, did you and the noncustodial parent sign a Declaration of Paternity? [] Yes [] N
If yes, in what County and State (attach a copy):
4. Were you married to and living with the noncustodial parent when you became pregnant? [] Yes [] N

INSTRUCTIONS: If you answered "NO" to all of the above questions, continue with Section II now and complete Sections II through X.

If you answered "YES" to questions 1 or 3, sign and date below. You do not need to complete Sections II through X. If you answered "YES" to question 4, you do not need to complete Sections II through X, UNLESS your husband was impotent or sterile at the time you became pregnant.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature_____
Date

(Complete the remaining sections of this questionnaire only if all your answers in Section I were "No")

SECTION II: ABOUT THE CHILD AND YOUR PREGNANCY

Important Note: If this child is not yet born, write down in the following space the date you expect this child to be born:

Expected due date / / Now, skip down to Item Number 4 in this Section.
MM DD CCYY

1. This child's birth date is: / / 2. This pregnancy was full term: [] Yes [] N
MM DD CCYY
3. The City and State in which this child was born are: _____
4. The City and State where you became pregnant: _____
5. The date you believe you became pregnant: _____
Mont Day (if Year
6. Doctor's name and address for this pregnancy are: _____

SECTION III: ABOUT THE CHILD'S MOTHER

1. Name: _____
Firs Middl Last Suffi
2. Address: _____
Street Unit

City State Zip
3. Social Security Number: _____-_____-_____ 4. Date of / /
MM DD CCYY

SECTION VII: ABOUT MY RELATIONSHIPS WITH OTHER MEN

1. Yes N I had sexual intercourse with someone other than the father of the child within 30 days before I believe I became pregnant. If "yes," please state the name and address of each person:
2. Yes N I had sexual intercourse with someone other than the father of the child within 30 days after I believe I became pregnant. If "yes," please state the name and address of each person:
3. Yes N I was married to someone other than the father when the child was born. If "yes," the person I was married to was:
4. Yes N I was married to someone other than the father when I became pregnant with the child. If "yes," the person I was married to was:
5. Yes N I was married when I became pregnant with the child.
6. Yes N I was married when the child was born.

SECTION VIII: ABOUT POSSIBLE WITNESSES WHO CAN SUPPORT MY CLAIM

1. Yes N There were other people present when I told the father I was pregnant with the child: If "yes," their names and addresses are:
2. Yes N There were other people present when I told the father I had given birth to the child. If "yes," their names and addresses are:
3. Yes N There were other people present when I first showed the child to the father. If "yes," their names and addresses are:
4. Yes N The father admitted to other people that he was the child's father. If "yes," state their names and addresses:
5. Yes N When I had sexual intercourse with the father, there were other people present or nearby. If "yes," state their names and addresses:
6. Yes N Other people have seen the father with me and/or the child. If "yes," state their names and addresses:
7. Yes N The father's parent's, or other family members, have spent time with the child. If "yes," state their names and addresses:

SECTION IX: ABOUT THE FATHER'S RELATIONSHIP WITH THE CHILD

1. Yes N The father was present when this child was born.
2. Yes N The father visited me and this child at the hospital after the child's birth.
3. Yes N The father has seen the child. If "yes," state what he said or did:
4. Yes N The father has provided food, clothing, gifts and/or other financial support for the child.
5. Yes N The father lived with this child. If "yes," state the time periods he lived with the child:
From: ___/___/___ to ___/___/___ From: ___/___/___ to ___/___/___
From: ___/___/___ to ___/___/___ From: ___/___/___ to ___/___/___
6. Yes N The father had his picture taken with the child. If "yes," please provide copies.

SECTION X: ADDITIONAL FACTS WHICH SUPPORT MY CLAIM

1. Yes N The father is listed on the child's birth certificate. If "no," state the name, if any, of the person listed as the child's father:

Why do you believe this person is not the child's real father?

2. Yes N I heard the father admit that he is the natural father of this child.
3. Yes N The father signed an acknowledgment of paternity. If "yes," please provide a copy of the acknowledgment.
4. Yes N I have letters from the father which talk about this child. If "yes," please provide copies.
5. Yes N The father offered to pay for me to get an abortion, or offered to pay for my medical expenses.
6. Yes N The father, or his insurance company, did in fact pay for some or all of my medical expenses.
7. Yes N The father has claimed this child on his tax returns.
 Don't know

8. Yes N The child looks like the father. If "yes," describe how the child looks like him:

9. Yes N There are more facts not mentioned above which support my claim. They are:

I have made all of the above responses as best as I can remember. I understand that I made these responses under penalty of perjury under the laws of the State of California.

Signature

Date

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name and Address): George O. Nielsen, Supervising Attorney CONTRA COSTA COUNTY DEPARTMENT of CHILD SUPPORT SERVICES 50 DOUGLAS DRIVE, SUITE 100 MARTINEZ, CA 94553 ATTORNEY FOR (Name) Pursuant to Family Code 17400 DCSS#	TELEPHONE NO.: (925) 957-7300	FOR COURT USE ONLY
SUPERIOR COURT OF CALIFORNIA, COUNTY OF CONTRA COSTA STREET ADDRESS: 751 PINE STREET MAILING ADDRESS: P. O. BOX 911 CITY AND ZIP CODE: MARTINEZ, CA 94553 BRANCH NAME:		
PETITIONER/PLAINTIFF: RESPONDENT/DEFENDANT:		
INCOME AND EXPENSE DECLARATION		CASE NUMBER:

Step 1 Attachments to this summary I have completed Income (page 2) Expense (page 3) Child Support (page 4) Information forms. (If child support is not an issue, do not complete Page 4. If your only income is TANF, do not complete Page 2.)

Step 2 Answer all questions that apply to you

1. Are you receiving or have you applied for or do you intend to apply for welfare or TANF?
 Receiving Applied for Intend to apply for No
2. What is your date of birth (month/day/year)? _____
3. What is your occupation? _____
4. Highest year of education completed: _____
5. Are you currently employed? Yes No
 - a. If yes: (1) Where do you work? (name and address) _____
 - (2) When did you start work there (month/year)? _____
 - b. If no: (1) When did you last work (month/year)? _____
 - (2) What were your gross monthly earnings? _____
6. What is the total number of minor children you are legally obligated to support? _____

Step 3 Monthly income information

7. Net monthly disposable income (from line 16a of Page 2): _____ \$
8. Current net monthly disposable income (if different from line 7, explain below or on Attachment 8): _____ \$

Step 4 Expense information

9. Total monthly expenses from line 2q of Page 3: _____ \$ _____
10. Amount of these expenses paid by others: _____ \$ _____

Step 5 Other party's income

11. My estimate of the other party's gross monthly income is: _____ \$ _____

Step 6 Date and sign this form I declare under penalty of perjury under the laws of the State of California that the foregoing and the attached information forms are true and correct.

Date:

(TYPE OR PRINT NAME)

(SIGNATURE OF DECLARANT)

Petitioner Respondent

PETITIONER/PLAINTIFF: RESPONDENT/DEFENDANT: INCOME INFORMATION OF (name):	CASE NUMBER:
---	--------------

1. Total gross salary or wages, including commissions, bonuses, and overtime paid during the last 12 months: 1. \$ _____
2. All other money received during the last 12 months except welfare, TANF, SSI, spousal support from this marriage, or any child support. Specify sources below:
 - Include pensions, social security, disability, unemployment, military basic allowance for quarters (BAQ), spousal support from a different marriage, dividends, interest or royalty, trust income, and annuities. _____ 2a. \$ _____
 - Include income from a business, rental properties, and reimbursement of job-related expenses. _____ 2b. \$ _____
 - Prepare and attach a schedule showing gross receipts less cash expenses for each business or rental property. _____ 2c. \$ _____
 - _____ 2d. \$ _____
3. Add lines 1 through 2d _____ 3. \$ _____
Divide line 3 by 12 and place result on line 4a.

	Average last 12 months:	Last month:
4. Gross income _____	4a. \$ _____	4b. \$ _____
5. State income tax _____	5a. \$ _____	5b. \$ _____
6. Federal income tax _____	6a. \$ _____	6b. \$ _____
7. Social Security and Hospital Tax ("FICA" and "MEDI") or self-employment tax, or the amount used to secure retirement or disability benefits _____	7a. \$ _____	7b. \$ _____
8. Health insurance for you and any children you are required to support _____	8a. \$ _____	8b. \$ _____
9. State disability insurance _____	9a. \$ _____	9b. \$ _____
10. Mandatory union dues _____	10a. \$ _____	10b. \$ _____
11. Mandatory retirement and pension fund contributions Do not include any deduction claimed _____	11a. \$ _____	11b. \$ _____
12. Court-ordered child support, court-ordered spousal support, and voluntarily paid child support in an amount not more than the guideline amount, actually being paid for a relationship other than that involved in this proceeding: _____	12a. \$ _____	12b. \$ _____
13. Necessary job-related expenses (attach explanation) _____	13a. \$ _____	13b. \$ _____
14. Hardship deduction (Line 4d on Page 4) _____	14a. \$ _____	14b. \$ _____
15. Add lines 5 through 14 _____ Total monthly	15a. \$ _____	15b. \$ _____
16. Subtract line 15 from 4 _____ Net monthly disposable	16a. \$ _____	16b. \$ _____

17. TANF, welfare, spousal support from this marriage, and child support from other relationships received each month: _____ 17 \$ _____
18. Cash and checking accounts: _____ 18 \$ _____
19. Savings, credit union, certificates of deposit, and money market accounts: _____ 19 \$ _____
20. Stock, bonds, and other liquid assets: _____ 20 \$ _____
21. All other property, real or personal (specify below): _____ 21. \$ _____

Attach a copy of your three most recent pay stubs.

PETITIONER/PLAINTIFF:	CASE NUMBER:
RESPONDENT/DEFENDANT:	
EXPENSE INFORMATION OF (name):	

1. a. List all persons living in your home whose expenses are included below and their income: <input type="checkbox"/> Continued on Attachment 1a.	1. <u>name</u> 2. 3. 4.	<u>age</u>	<u>relationship</u>	<u>gross monthly income</u>
b. List all other persons living in your home and their income: <input type="checkbox"/> Continued on Attachment 1b.	1. 2. 3.			

2. MONTHLY EXPENSES

a. Residence payments (1) <input type="checkbox"/> Rent or <input type="checkbox"/> mortgage _____ \$ _____ (2) If mortgage, include: Average principle _____ \$ _____ Average interest _____ \$ _____ Impound for real property taxes _____ \$ _____ Impound for homeowner's insurance _____ \$ _____ (3) Real property taxes (if not included in item (2)) _____ \$ _____ (4) Homeowner's or renter's insurance (if not included in item (2)) _____ \$ _____ (5) Maintenance _____ \$ _____ b. Unreimbursed medical and dental expenses _____ \$ _____ c. Child care _____ \$ _____ d. Children's _____ \$ _____	e. Food at home and household supplies. \$ _____ f. Food eating out _____ \$ _____ g. Utilities _____ \$ _____ h. Telephone _____ \$ _____ i. Laundry and cleaning _____ \$ _____ j. Clothing _____ \$ _____ k. Insurance (life, accident, etc. Do not include auto, home, or health insurance) \$ _____ l. Education (specify): _____ \$ _____ m. Entertainment _____ \$ _____ n. Transportation and auto expenses (insurance, gas, oil, repair) _____ \$ _____ o. Installment payments (insert total and itemize below in item 3) _____ \$ _____ p. Other (specify): _____ \$ _____ q. TOTAL EXPENSES (a-p) _____ \$ _____ (do not include amounts in a(2))
--	--

3. ITEMIZATION OF INSTALLMENT PAYMENTS OR OTHER DEBTS Continued on Attachment 3.

CREDITOR'S NAME	PAYMENT FOR	MONTHLY PAYMENT	BALANCE	DATE LAST PAYMENT MADE

4. ATTORNEY FEES

a. To date I have paid my attorney for fees and costs: \$ The source of this money was:

b. I owe to date the following fees and costs over the amount paid:

c. My arrangement for attorney fees and costs is:

I confirm this information and fee arrangement.

(SIGNATURE OF ATTORNEY)

(TYPE OR PRINT NAME OF ATTORNEY)

PETITIONER/PLAINTIFF:	CASE NUMBER:
RESPONDENT/DEFENDANT:	
CHILD SUPPORT INFORMATION OF (name):	

THIS PAGE MUST BE COMPLETED IF CHILD SUPPORT IS AN ISSUE.

1. Health insurance for my children i is not available through my employer.
 - a. Monthly cost paid by me or on my behalf for the children only is: \$ _____
Do not include the amount paid or payable by your
 - b. Name of carrier:
 - c. Address of carrier:
 - d. Policy or group policy number:

2. Approximate percentage of time each parent has primary physical responsibility for the
Mother _____ % Father _____ %

3. The court is requested to order the following as additional child support:
 - a. Child care costs related to employment or to reasonably necessary education or training for employment
 - (1) Monthly amount currently paid by mother: \$
 - (2) Monthly amount currently paid by father: \$
 - b. Uninsured health care costs for the children (for each cost state the purpose for which the cost was incurred and the estimated monthly, yearly, or lump sum amount paid by each parent):
 - c. Educational or other special needs of the children (for each cost state the purpose for which the cost was incurred and the estimated monthly, yearly, or lump sum amount paid by each parent):
 - d. Travel expenses for visitation
 - (1) Monthly amount currently paid by mother: \$
 - (2) Monthly amount currently paid by father: \$

4. The court is requested to allow the deductions identified below, which are justifiable expenses that have caused an extreme financial hardship.

	Amount paid per month	How many months will you need to make these payments
a. <input type="checkbox"/> Extraordinary health care expenses (specify and attach any supporting documents):	\$ _____	_____
b. <input type="checkbox"/> Uninsured catastrophic losses (specify and attach supporting documents):	\$ _____	_____
c. <input type="checkbox"/> Minimum basic living expenses of dependent minor children from other marriages or relationships who live with you (specify names and ages of these children):	\$ _____	_____
d. Total hardship deductions requested (add lines)		
	\$ _____	

CHILD CARE VERIFICATION

APPLICANT NAME: _____

I am the Custodial Party Noncustodial Parent

APPLICANT: Give your child care provider this form to complete. Attach any receipts or copies of canceled checks for child care that you may have.

CHILD CARE PROVIDER: Complete the appropriate section(s) for the children of the above named applicant for whom you provide child care.

SECTION I: INFANT & PRE-SCHOOL CHILDREN

Name of Provider/Day Care Center _____

Address _____ Apt. or Unit No. _____

City _____ State _____ Zip _____ Phone () _____

Name of Person or persons who pay(s) you for childcare _____

Name of the children of this parent for whom you provide care and the amount you receive.

Child _____	Amount \$ _____	(Circle One) per week/month/day
Child _____	Amount \$ _____	per week/month/day
Child _____	Amount \$ _____	per week/month/day
Child _____	Amount \$ _____	per week/month/day
Total: \$ _____		per week/month/day

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

(Signature of Child Care Provider) Date: _____

SECTION II: SCHOOL-AGE CHILDREN

A. For child care provided during regular school sessions:

Name of Provider/Day Care Center _____

Address _____ Apt. or Unit No. _____

City _____ State _____ Zip _____ Phone () _____

Name of Person or persons who pay(s) you for childcare _____

Name of the children of this parent for whom you provide care and the amount you receive.

Child _____	Amount \$ _____	(Circle One) per week/month/day
Child _____	Amount \$ _____	per week/month/day
Child _____	Amount \$ _____	per week/month/day
Child _____	Amount \$ _____	per week/month/day
Total: \$ _____		per week/month/day

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

(Signature of Child Care Provider) Date: _____

CONTINUED ON REVERSE

SECTION II: SCHOOL-AGE CHILDREN continued

B. For summer/vacation care for school-age children, attach receipts or canceled checks. Include these amounts in the information specified below.

Name of Provider/Day Care Center _____

Address _____ Apt. or Unit No. _____

City _____ State _____ Zip _____ Phone () _____

Name of Person or persons who pay(s) you for childcare _____

Name of the children of this parent for whom you provide care and the amount you receive.

Child _____	Amount \$ _____	(Circle One) per week/month/day
Child _____	Amount \$ _____	per week/month/day
Child _____	Amount \$ _____	per week/month/day
Child _____	Amount \$ _____	per week/month/day
	Total: \$ _____	per week/month/day

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

(Signature of Child Care Provider) Date: _____

HEALTH INSURANCE INFORMATION

Page 1 of 2

FULL NAME (First, Middle, Last, Suffix)

<input type="checkbox"/>	CUSTODIAL PARTY
<input type="checkbox"/>	NONCUSTODIAL PARENT

SECTION I: YOUR INSURANCE

Complete this section if your insurance is provided or available through your employer or a private policy maintained by you and not the other parent. Section II is about the insurance provided by the other parent.

HEALTH INSURANCE

Do you currently have Health Insurance coverage? YES NO If YES, complete the following information.

HEALTH INSURANCE COMPANY

INSURANCE COMPANY'S ADDRESS: Street, Apt. or Unit No. (Address where claims are mailed)

City, State, Zip Code	POLICY NO.
-----------------------	------------

PREMIUM DEDUCTION AMOUNT	CHECK ONE: <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> SEMI-MONTHLY <input type="checkbox"/> MONTHLY	AMOUNT PAID BY EMPLOYER
AMOUNT PAID BY YOU	CHECK ONE: <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> SEMI-MONTHLY <input type="checkbox"/> MONTHLY	

NAME(S) OF DEPENDENTS CURRENTLY COVERED BY HEALTH INSURANCE	DEPENDENT'S POLICY NO.
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Check here if names & policy numbers of additional dependents covered by Health Insurance are listed on a separate sheet attached.

DENTAL INSURANCE

Do you currently have Dental Insurance coverage? YES NO If YES, complete the following information.

DENTAL INSURANCE COMPANY

INSURANCE COMPANY'S ADDRESS: Street, Apt. or Unit No. (Address where claims are mailed)

City, State, Zip Code	POLICY NO.
-----------------------	------------

PREMIUM DEDUCTION AMOUNT	CHECK ONE: <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> SEMI-MONTHLY <input type="checkbox"/> MONTHLY	AMOUNT PAID BY EMPLOYER
AMOUNT PAID BY YOU	CHECK ONE: <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> SEMI-MONTHLY <input type="checkbox"/> MONTHLY	

NAME(S) OF DEPENDENTS CURRENTLY COVERED BY DENTAL INSURANCE	DEPENDENT'S POLICY NO.
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Check here if names & policy numbers of additional dependents covered by Dental Insurance are listed on a separate sheet attached.

VISION INSURANCE

Do you currently have Vision Insurance coverage? YES NO If YES, complete the following information.

VISION INSURANCE COMPANY

INSURANCE COMPANY'S ADDRESS: Street, Apt. or Unit No. (Address where claims are mailed)

City, State, Zip Code

POLICY NO.

PREMIUM DEDUCTION AMOUNT	CHECK ONE: <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> SEMI-MONTHLY <input type="checkbox"/> MONTHLY	AMOUNT PAID BY EMPLOYER
AMOUNT PAID BY YOU	CHECK ONE: <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> SEMI-MONTHLY <input type="checkbox"/> MONTHLY	

NAME(S) OF DEPENDENTS CURRENTLY COVERED BY VISION INSURANCE	DEPENDENT'S POLICY NO.
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Check here if names & policy numbers of additional dependents covered by Vision Insurance are listed on a separate sheet attached.

SECTION II: OTHER PARENT'S INSURANCE

HEALTH INSURANCE

Does the other parent currently provide Health Insurance coverage for the children or you? YES NO If YES, complete the following information.

HEALTH INSURANCE COMPANY

INSURANCE COMPANY'S ADDRESS: Street, Apt. or Unit No. (Address where claims are mailed)

City, State, Zip Code

DENTAL INSURANCE

Does the other parent currently provide Dental Insurance coverage for the children or you? YES NO If YES, complete the following information.

DENTAL INSURANCE COMPANY

INSURANCE COMPANY'S ADDRESS: Street, Apt. or Unit No. (Address where claims are mailed)

City, State, Zip Code

VISION INSURANCE

Does the other parent currently provide Vision Insurance coverage for the children or you? YES NO If YES, complete the following information.

VISION INSURANCE COMPANY

INSURANCE COMPANY'S ADDRESS: Street, Apt. or Unit No. (Address where claims are mailed)

City, State, Zip Code



REVIEW AND ADJUSTMENT PROCEDURE **IMPORTANT NOTICE**

If in the future you request that the Department of Child Support Services review your order for a possible modification, the department wants you to be aware of the following important information before you make the decision to request the review.

1. The Department of Child Support Services provides child support services on behalf of the State of California and does not represent you as your private attorney. Our primary function is to collect past due child support.
2. The Department of Child Support Services is not required to review an order if: 1) the order was reviewed for modification within the prior 12 months; 2) the order was established or adjusted within the prior 24 months; or 3) one of the parents cannot be located and there is no new information regarding his or her whereabouts.
3. The amount of the child support order may be modified by increasing or decreasing the order based on financial or other information that both the custodial parent and non-custodial parent provide.
4. Once the Department of Child Support Services has determined that an order will be reviewed, the Department of Child Support Services has up to 180 days to modify the order. If you feel that this amount is too long, you should seek assistance from a private attorney.
5. The Department of Child Support Services must provide services to thousands of cases and only has limited time and resources to devote to your case. This includes phone calls and office visits. Give us the time to evaluate your case, and you will be sent the results in writing or contacted if we need further information. If you feel your case requires additional services, you may choose to retain private counsel to modify your support order.
6. You must cooperate with the Department of Child Support Services in providing all documents as requested. You must complete your income and expense form accurately. Failure to cooperate will cause the closure of your case.
7. If the Department of Child Support Services is not required to modify the order, you may seek the assistance of the Court Facilitator, a private attorney, a legal aid clinic or you may obtain the modification forms yourself from the Contra Costa County Clerk's Office located at 751 Pine Street, Martinez, CA 94553.

I CERTIFY THAT I HAVE READ ALL OF THE FOREGOING INFORMATION.

DATED: _____ SIGNED: _____

DCSS #: _____ PRINT FULL NAME: _____

DECLARATION OF CUSTODIAN

I, the undersigned, declare:

1. I am the custodian of the child(ren) in this case, _____

who is/are residing with me at the present time.

2. The non-custodial parent of the child(ren) is _____

3. My income is (fill in all information that applies):

a. I am presently employed as a _____ and my net monthly
income from work is approximately \$ _____ per _____.

b. My monthly income from welfare benefits is \$ _____ per _____.

c. Other (specify any other income sources): _____

4. My monthly day care expense is \$ _____ per _____ paid to

_____.

5. The non-custodial parent's income is:

a. The non-custodial parent is working as a _____ and
usually earns approximately \$ _____ per _____.

b. The non-custodial parent has previously worked as a _____ and
usually earned approximately \$ _____ per _____.

c. Other (specify any other income sources): _____

6. The no-custodial parent's visitation with the child(ren) in the past 12 months has been a
total of _____ days.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: _____

Signature

Type or print name

CHILD SUPPORT DOMESTIC VIOLENCE QUESTIONNAIRE

NOTICE: If you do not complete and return this form, the federal government will release information about you or your child's whereabouts to other child support agencies, and possibly to the child's other parent.

Your name: _____

Case No.: _____

Other party's name: _____

SECTION I: Check the appropriate box for each of the questions.

1. Have you or a child in your care ever been a victim of domestic violence or child abuse committed by the other party to your child support case? Yes No

2. Have you ever obtained a restraining order, emergency protective order or stay away order against the other party to your child support case? Yes No

If "Yes", please attach a copy of this order and provide the following information:

County/State: _____ Court Case Number: _____

Expiration Date: _____

3. If you or a child in your care receive public assistance, do you want to claim "Good Cause" because of increased risk of physical, sexual, or emotional harm to you or your child, and request that the welfare department authorize that your support case be closed? Yes No

SECTION II: You **MUST** complete this section **if you** answered "yes." to any item in Section I.

Please provide detailed domestic violence information including dates, times, places and witnesses (Attach additional pages if needed.)

SECTION III: Check the appropriate box, sign, date and return the form to the local child support agency.

The disclosure of my address or other information identifying my location could be harmful to me or the child(ren) in my care. I am requesting that my address or other identifying information not be given to the other party in this case. This request for non-disclosure of information will remain in effect until I notify the local child support agency in writing, and the office that manages my case acknowledges that they have received my request. I understand that under federal law, an authorized person may submit a written request to the court which has jurisdiction to make or enforce child custody or visitation determinations. I will be notified in writing by the local child support agency if the court orders the release of information on my case.

The disclosure of my address or other information identifying my location is not harmful to me or the child(ren) in my care. I understand this information will be made available to the federal government, courts, child support agencies and sometimes to the other parent of the child(ren).

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: _____

Signature