

Mississippi Department of Human Services
Application for Child Support Services

I, \_\_\_\_\_, am applying or have been referred for child support services.
First Middle Maiden Last

CHILD(REN) INFORMATION: Information relating to the child(ren) born from the relationship between one set of parents. A separate application will be completed when children are not born to one set of parents. For example: The biological mother is the applicant. She has children by two different fathers. The child(ren) from each father will need to be listed on separate applications.

1st Child's Name \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Eth: \_\_\_\_\_
City & State of Birth: \_\_\_\_\_ Relationship to CP: \_\_\_\_\_

2nd Child's Name \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Eth: \_\_\_\_\_
City & State of Birth: \_\_\_\_\_ Relationship to CP: \_\_\_\_\_

For additional children, please complete the supplemental information form.

Do the children have health insurance coverage? [ ] Yes [ ] No

If yes, please list who is providing the insurance: [ ] Custodial Parent [ ] Parent Responsible for Support [ ] Medicaid

The name of the child's provider \_\_\_\_\_

Group/Policy number: \_\_\_\_\_

Are the children citizens of the United States of America? [ ] Yes [ ] No If no, please list each child's name and country of citizenship:

\_\_\_\_\_
\_\_\_\_\_

CUSTODIAL PARENT (CP) INFORMATION: Information relating to the person who has physical custody of the children. The CP could be the child(ren)'s mother, father or another adult.

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Last Completed Grade: \_\_\_\_\_

Is the CP a United States of America citizen? [ ] Yes [ ] No If no, what is the country of citizenship? \_\_\_\_\_

Email Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Mobile Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

Employer Telephone Number: \_\_\_\_\_

**Relationship to the parent responsible for support:**

- Married: Date of Marriage: \_\_\_\_\_ County and State of Marriage: \_\_\_\_\_
- Divorced: Divorce Date: \_\_\_\_\_ Place of Divorce: \_\_\_\_\_
- Separated  Never Married  Other Relationship: Explain: \_\_\_\_\_

**INFORMATION REGARDING THE PARENT RESPONSIBLE FOR SUPPORT (PRFS):** Information of the parent who does not have primary physical custody of the children.

The PRFS could be the mother or father of the child(ren). For example, a child lives with the father. The mother of the child is the PRFS.

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Sex: \_\_\_\_\_

DOB: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Eye

Color: \_\_\_\_\_ Last Completed Grade: \_\_\_\_\_

Describe Scars/Tattoos: \_\_\_\_\_

Other names used: \_\_\_\_\_

Is the PRFS a citizen of the United States of America?  Yes  No If yes, please list the city and state of birth: \_\_\_\_\_

If the PRFS is not a citizen of the United States of America, please list the country of citizenship? \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Telephone Numbers for the PRFS: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Other: \_\_\_\_\_

Is the PRFS currently incarcerated:  Yes  No  Unknown

PRFS Employer Name and Address: \_\_\_\_\_

Employer Telephone Number: \_\_\_\_\_

If the PRFS has multiple employers, please complete additional information on the supplemental information form.

Does the PRFS have Health Insurance Coverage?  Yes  No If yes, please list the children that are covered on PRFS insurance below:

Is the PRFS currently ordered to pay child support for the child(ren) named above?  Yes  No

If yes, please provide the following details about the order:

Amount: \$ \_\_\_\_\_ Date of Order: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_

**PRFS Relationship to Child(ren):**

- Parents were married when the child(ren) were conceived/born
- Alleged parent, paternity not established
- PRFS is the mother
- Legal father with paternity established by one of the following methods:
  - In Hospital Paternity (signed the birth certificate)  Genetic Testing  Court Order  Stipulated Agreement:  Other, specify: \_\_\_\_\_
  - What date was paternity established: \_\_\_\_\_

Is the name of the parent responsible for support on the child's birth certificate?  Yes  No

**Please use this space to provide additional information about the PRFS, such as information related to the PRFS' finances, location, work history, college degrees or certificates, past addresses and other sources of income:** \_\_\_\_\_

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**OTHER BIOLOGICAL PARENT (OBP)/LEGAL PARENT INFORMATION:** The OBP is the other legal/biological parent (not the PRFS above) in cases when the child(ren) live with someone other than a legal/biological parent. This section should be completed when the CP is someone other than the mother or father. For example, a child lives with a grandparent who has guardianship or custody of the child. The grandparent is the CP. If the father is listed as the PRFS above, the mother would be the OBP below.

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Sex: \_\_\_\_\_

DOB: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Eye

Color: \_\_\_\_\_ Last Completed Grade: \_\_\_\_\_

Describe

Scars/Tattoos:

Other names used: \_\_\_\_\_

Is the OBP a citizen of the United States of America? Yes  No

If yes, please list the city and state of birth: \_\_\_\_\_

If the OBP is not a citizen of the United States of America, please list the country of citizenship? \_\_\_\_\_

Email Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

Telephone Numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Is the OBP currently incarcerated: Yes No Unknown

Employer Name and Address: \_\_\_\_\_

Employer Telephone number: \_\_\_\_\_

If the OBP has multiple employers, please complete additional information on the supplemental information form.

Does the OBP have Health Insurance Coverage? Yes No If yes, please list the children that are covered on OBP insurance below:

What is the OBP's relationship to the CP? Child Married Never Married Divorced Separated Other, specify \_\_\_\_\_

What is the OBP's relationship to the PRFS? Married Never Married Divorced Separated Other, specify \_\_\_\_\_

Please use this space to provide additional information about the OBP, such as information related to the OBP's finances, location, work history, college degrees or certificates, past addresses and other sources of income: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I authorize the Mississippi Department of Human Services (MDHS) to perform the following type of service:****Please only check  one box**

- Locate only services.** (MDHS would attempt to locate the PRFS. Public Assistance cases may not choose locate only.)
- Income Withholding Disbursement Services Only.** (MDHS would not provide any other type of enforcement, and if the PRFS' employment changes, MDHS would not automatically issue a new withholding order. (Public Assistance cases may not choose this service.)
- Full services that are listed below:**
- Locate the noncustodial parent;
  - Establish the legal paternity of my child(ren);
  - Get a legal order for child support, including medical insurance, for the child(ren), or get an amendment to the child support order if one already exists;
  - Enforce the child support order by any way permitted by law;
  - Collect and distribute child support payments according to Federal guidelines and the laws of the State of Mississippi;
  - Disclose my circumstances in pleadings or other documents filed in a proceeding to enforce/determine child support for my child(ren). I understand that I am entitled to a determination of good cause if my or my child(ren)'s health, safety or liberty would be unreasonably put at risk if information concerning my circumstances is disclosed as stated above.

**In some cases, MDHS may request that the PRFS be ordered to pay support up to one year before application. Not all cases qualify for prior support, and a request does not guarantee prior support will be awarded or paid.**

- Would you like MDHS to pursue prior support? check  one:  Yes  No

**SAFETY CONCERNS:** MDHS takes safety of families very seriously and can modify some processes to help with safety concerns. Disclosure is not a criminal allegation against any party in this case. Instead, this information is used by MDHS to better manage your case and protect your information. MDHS treats this disclosure as confidential and will not reveal it to any other party, including another parent.

To better understand your safety concerns, please check  all boxes that apply:

- The other parent does not know I am applying for services, and I am concerned about the other parent's reaction.
- I have a restraining order against the other parent.
- I am concerned about the other parent getting my address and contact information.
- I am afraid of the other parent.
- I am afraid of seeing the other parent in court or in MDHS offices.
- The other parent has been convicted of domestic violence or another related crime (assault, sexual battery, stalking, etc.)

I am receiving public assistance benefits, such as SNAP/TANF/MEDICAID, and the following circumstances apply to my (check  all that apply)

- The child(ren) were conceived by either rape or incest.
- A child listed on this application has been convicted of a felony and sentenced to two (2) or more years.
- Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.
- I am receiving assistance from a public or licensed private social service agency to help me determine whether I should allow my children to be adopted.

**NOTICE OF RIGHT TO CLAIM GOOD CAUSE FOR NOT COOPERATING:** "Good Cause" means that there is a reason, due to potential physical or emotional harm to you or your child why you do not want child support at this time. If establishing paternity or collecting support could harm you or your children, and you can provide information about the safety risk(s), the law allows you to apply for good cause to not cooperate in the child support program.

**Good Cause Claim (check  one):**

- I do not wish to make a good cause claim.
- I am making a claim of good cause for not cooperating with the child support agency in establishing paternity and/or in collecting child support for my child(ren); I know I must give any information I can to support my claim, and this claim must be approved by MDHS.

**By signing this application, I understand that:**

- I have assigned to MDHS any and all rights and interests in any cause of action past, present, or future that I or the child(ren) included in this application may have against any parent failing to provide for the support of the minorchild(ren);
- A non-refundable fee of \$25 will be charged as an application fee and to recover the costs of any services performed for applicants who are not receiving public assistance [Temporary Assistance for Needy Families, (TANF) or Supplemental Nutritional Assistance Program (SNAP)]. No action will be taken until the application fee is paid;
- A non-refundable annual fee of \$35 will be collected from distributed child support in excess of \$550 for each October – September annual period for applicants who are not currently receiving Supplemental Nutritional Assistance Program (SNAP) benefits and who have never received Temporary Assistance for Needy Families (TANF) benefits. This amount will be collected from the next distributed payment or payments until the fee is paid in full;
- There may be additional fees necessary, such as: court costs, filing fees, service of process fees;
- I will receive the first \$100 of child support paid during a month in which I receive TANF benefits. This amount of child support will not be considered part of my family income and will not affect my TANF eligibility. However, this support amount may be considered part of my family income and may affect the amount of other benefits, such as SNAP, provided to my household;
- MDHS does not guarantee that efforts on my behalf will be successful;
- If I do not cooperate with MDHS, my case may be closed after advance notice, and public assistance offices will be notified, if applicable, except for approved claims of Good Cause. Public assistance includes, but is not limited to, the SNAP/TANF office, Medicaid office, and/or Child Care office.
- I understand the criminal penalties for making false statements and false swearing and do hereby attest to the truthfulness of the information provided. [False swearing is punishable by a fine of not more than \$1,000 or by imprisonment of one year or both.];
- If I have an existing support order, upon paying the application fee for child support services, payments will be automatically directed to MDHS. Upon my request to close my child support case, it is my responsibility to have the payments redirected in court;
- It is my responsibility to notify MDHS of any direct payments I receive from the noncustodial parent or any subsequent child support orders I obtain;
- If I receive any money that was sent to me in error, the overpayment must be repaid by me;
- MDHS has the ability to recoup fraudulent or erroneous IRS returns at 100% from all available methods (meaning debit cards, future payments, etc.)
- The state staff attorney and/or private contract attorney providing services pursuant to this application for child support services:
  - Does not represent me in any action which may occur.
  - Represents only the state and the state’s interest.
  - Cannot give me any legal advice; further, I understand that if I want legal advice I should contact my own attorney.
  - Does not deal with custody or visitation rights.
- That any monies herein paid by me are not attorney fees;
- I and/or the other parent each have the right to request a review, in writing, of the support obligation every three years to ensure the amount is appropriately based on established guidelines, and this review may result in an increase or decrease in the child support obligation; and,
- No fee will be charged for parent locate only cases or Income Withholding Disbursement Services Only cases;
- I must apply for and cooperate with child support enforcement as a condition of eligibility for a child care certificate and other public assistance; and
- I must notify MDHS immediately when I have a change of address.

If I am requesting services as a custodial or other biological parent, I acknowledge that a child support worker will contact the noncustodial parent and set up a meeting with him/her to attempt to reach an agreement to pay child support. The amount of child support will be based on his/her income. If I have any information that has not been provided on this application and MDHS should know prior to this meeting (such as the noncustodial parents’ income, employer, etc.), I must contact the child support worker immediately. MDHS will use all information provided when determining the amount of child support to be ordered.

If I am requesting services as a custodial parent, I understand my signature will serve as an authorization for MDHS to issue child support payments to me on a debit card. I have received the disclosures related to the debit card transaction fees. I understand that I have the option to choose to enter into a direct deposit agreement with MDHS instead. MDHS will issue payments on the debit card until I request to enter into a direct deposit agreement, have completed and submitted the necessary forms, and have given MDHS and my financial institution reasonable time to setup direct deposit transactions.

**Under the penalty of perjury, I do hereby swear and affirm that I have read all the information provided on this application and that the information I provided on this Application for Child Support Services is accurate and true to the best of my knowledge.**

Applicant’s signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Please mail your completed application with a check or money order for \$25.00 to:

MDHS-Division of Child Support  
950 E. County Line Rd.  
Suite G  
Ridgeland, MS 39157

**Official Use Only:**  
DATE RECEIVED: \_\_\_/\_\_\_/\_\_\_  
WORKER ID: \_\_\_\_\_  
CASE ID: \_\_\_\_\_  
APPLICANT: CP PRFS OBP  
TYPE OF SERVICE: Locate IWO Full Service  
FAMILY VIOLENCE INDICATOR REVIEWED AND FLAGGED: Yes No NA  
GOOD CAUSE DETERMINATION MADE: Yes No NA  
DATE PROCESSED: \_\_\_/\_\_\_/\_\_\_  
614 DISTRIBUTED: Yes No  
577 COMPLETED: Yes No NA  
DIRECT DEPOSIT DISCLOSURES GIVEN: Yes No NA

### Supplemental Information

**ADDITIONAL CHILD(REN) INFORMATION:** If you are applying for services for more than two children for the same father, complete the below information for the additional child(ren). You may print as many of these pages necessary to provide all information.

Child's Name \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Eth: \_\_\_\_\_  
City & State of Birth: \_\_\_\_\_ Relationship to CP: \_\_\_\_\_

Child's Name \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Eth: \_\_\_\_\_  
City & State of Birth: \_\_\_\_\_ Relationship to CP: \_\_\_\_\_

Child's Name \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Eth: \_\_\_\_\_  
City & State of Birth: \_\_\_\_\_ Relationship to CP: \_\_\_\_\_

Child's Name \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Eth: \_\_\_\_\_  
City & State of Birth: \_\_\_\_\_ Relationship to CP: \_\_\_\_\_

Child's Name \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Eth: \_\_\_\_\_  
City & State of Birth: \_\_\_\_\_ Relationship to CP: \_\_\_\_\_

Do the children have health insurance coverage? Yes No

Are the children citizens of the United States of America? Yes No If no, please list each child's name and country of citizenship: \_\_\_\_\_

**EMPLOYER INFORMATION:** Please provide additional employer information below:

Employer Name and Address: \_\_\_\_\_  
Employer Telephone number: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_  
Employer Telephone number: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_  
Employer Telephone number: \_\_\_\_\_

Applicant's signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_