IV-D CHILD SUPPORT SERVICES APPLICATION/REFERRAL

Michigan Department of Health and Human Services
Office of Child Support (OCS)

FOR OFFICE USE ONLY

Date Requested	Date Provided	Date Filed	Program	☐ 748 Provided
IV-D Case No.	MDHHS Case No.	County	District	Unit	Worker

Please check your relationship to the children for whom you are applying for child support services:

☐ Custodial Parent ☐ Non-Custodial Parent or Alleged Father ☐ Other Caretaker, Specify _____

- **Custodial Parent** - Complete all sections of the form, enter information about you in Section A.
- **Non-Custodial Parent or Alleged Father** – Complete all sections of the form except Section F, enter information about you in Section B.
- **Other Caretaker** - Complete all sections of the form, enter information about you in Section A. Complete information about each parent who is not in the home in Section B. (Please complete a separate application for each parent who is not in the home.)

A. INFORMATION ABOUT THE CUSTODIAL PARENT/CARETAKER OF THE CHILD

1. Name (First, Middle, Last, Suffix)	Maiden Name (If applicable)	2. Birthdate	3. Social Security No.
4. Home Address (P.O. Box No., No. and Street)	City	State	Zip Code	County
5. Home Phone No. ( )	6. Work Phone No. ( )	7. Cell Phone No. ( )	

B. INFORMATION ABOUT THE PARENT WHO IS NOT IN THE HOME

8. Parent's Name (First, Middle, Last, Suffix)	Maiden Name (If applicable)	9. Social Security No.	10. Birthdate	11. Age	12. Sex (M or F)
13. Home Address (P.O. Box No., No. and Street) ☐ Current ☐ Last Known	City	State	Zip Code	14. Home Phone No. ( )	15. Cell Phone No. ( )
16. Weight	17. Height	18. Hair Color	19. Eye Color		
20. Birthplace (City, State)	21. Driver's License Number	22. Car (Make, Model and Year)	23. License Plate Number		

24. Race or Ethnic Code:

__ Alaskan Native	__ Hispanic	__ White
__ American Indian	__ Multiracial – More than one racial-ethnic group	__ Middle Eastern
__ Asian or Pacific Islander	__ Black, not of Hispanic origin	__ Other

25. Any Visual Marks or Scars?

26. First Employer Name ☐ Current ☐ Last Known	27. Employer Address (P.O. Box No., No. and Street)	City	State	Zip Code	28. Phone No. ( )
29. Second Employer Name ☐ Current ☐ Last Known	30. Employer Address (P.O. Box No., No. and Street)	City	State	Zip Code	31. Phone No. ( )

C. MARITAL STATUS INFORMATION

32a. Has the mother ever married? ☐ No ☐ Yes, If Yes>>	b. Name of Spouse		c. Date Married	d. Place (City, County, State)
33a. Is the mother ☐ Separated ☐ Legally Separated >>	b. Date	c. Court Order Exist? ☐ No ☐ Yes, If Yes>>	d. Court Order No.	e. Where (City, County, State)
34a. Is the mother ☐ Divorced ☐ Divorce filed >>	b. Date	c. Court Order Exist? ☐ No ☐ Yes, If Yes>>	d. Court Order No.	e. Where (City, County, State)

Please attach a copy of all court orders pertaining to the family members listed on this application, including Personal Protection Orders and guardianship papers.

D. INFORMATION ABOUT CHILD(REN)

Child One (Please include separate pages if more than three children)

35a. Child's Full Name (First, Middle, Last, Suffix)	b. Birthdate	c. Social Security Number	d. Sex (M or F)
e. City, County & State of Birth	f. Who paid for the birth of child (Medicaid, Private Insurance, Mother, Father, Other)?		

g. When and where did the mother become pregnant?

Date	City	County	State

h. Has the father completed a document admitting he is the father of the child, such as an Affidavit of Parentage or is there a court order establishing paternity? ☐ Yes ☐ No
If yes, provide the following information about that document:

Date	City	County	State

CHILD'S HEALTH CARE COVERAGE INFORMATION (attach copy of card(s), front & back)

36a. Policy Holder's Name	b. Health Care Company Name (Non-Medicaid)	c. Coverage Type PPO ☐ PPOM ☐ Traditional ☐	d. Policy or Group No.

Child Two

37a. Child's Full Name (First, Middle, Last, Suffix)	b. Birthdate	c. Social Security Number	d. Sex (M or F)
e. City, County & State of Birth	f. Who paid for the birth of child (Medicaid, Private Insurance, Mother, Father, Other)?		

g. When and where did the mother become pregnant?

Date	City	County	State

h. Has the father completed a document admitting he is the father of the child, such as an Affidavit of Parentage or is there a court order establishing paternity? ☐ Yes ☐ No
If yes, provide the following information about that document:

Date	City	County	State

CHILD'S HEALTH CARE COVERAGE INFORMATION (attach copy of card(s), front & back)

38a. Policy Holder's Name	b. Health Care Company Name (Non-Medicaid)	c. Coverage Type PPO ☐ PPOM ☐ Traditional ☐	d. Policy or Group No.

Child Three

39a. Child's Full Name (First, Middle, Last, Suffix)	b. Birthdate	c. Social Security Number	d. Sex (M or F)
e. City, County & State of Birth	f. Who paid for the birth of child (Medicaid, Private Insurance, Mother, Father, Other)?		

g. When and where did the mother become pregnant?

Date	City	County	State

h. Has the father completed a document admitting he is the father of the child, such as an Affidavit of Parentage or is there a court order establishing paternity? ☐ Yes ☐ No
If yes, provide the following information about that document:

Date	City	County	State

CHILD'S HEALTH CARE COVERAGE INFORMATION (attach copy of card(s), front & back)

40a. Policy Holder's Name	b. Health Care Company Name (Non-Medicaid)	c. Coverage Type PPO ☐ PPOM ☐ Traditional ☐	d. Policy or Group No.

E. GENERAL INFORMATION

41. I believe that disclosure of my address or other identifying information may result in physical or emotional harm to me or the child. ☐ Yes ☐ No

42. I have received or I am currently receiving benefits from the Family Independence Program (FIP) or I have received past benefits from Aid to Dependent Children (ADC).
☐ Yes ☐ No

If yes, when? Where?

43. I have received or I am currently receiving Medicaid (MA). ☐ Yes ☐ No

If yes, when? Where?

44. I am currently receiving: Food Assistance Program (FAP) ☐ Yes ☐ No Child Development and Care (CDC) ☐ Yes ☐ No

F. ACKNOWLEDGEMENT FOR CUSTODIAL PARENTS AND CARETAKERS

The Michigan Office of Child Support (OCS) processes child support payments through the Michigan State Disbursement Unit (MiSDU), which is part of the Michigan Department of Health and Human Services (MDHHS). The MiSDU receipts and distributes payments by direct deposit to a bank account, to a debit card, or by paper check.

If I am sent money in error or overpaid, the MiSDU will take all the necessary steps to correct errors in the processing of my child support payments. By checking the "yes" box below, I give OCS permission to withhold an incremental amount specified below from future child support payments owed to me. To revoke my consent, I must notify the Friend of the Court office. Failure to check "yes" has no effect on my eligibility for IV-D Child Support services through OCS.

☐ Yes, (circle one) 10% 25% or 50% Failure to choose a percentage will result in a default amount of 25%.

☐ No, please contact me before you attempt to recover an amount from my support payments.

G. ACKNOWLEDGEMENT FOR ALL APPLICANTS

I request child support services available under Title IV-D of the Social Security Act.

☐ All Services
☐ Locate Only (for custodial parents and caretakers only)
☐ Medical Support Only (for Medicaid cases only)

I understand that disclosure of my Social Security number is mandated by the Social Security Act, 42 USC 666(a)(13), in order that Michigan's child support program may provide services related to the establishment of paternity and the establishment, modification and enforcement of child support obligations. I understand that I must cooperate in taking support action to ensure that my child support case remains open. I declare that the information provided above is true and correct to the best of my knowledge and agree to report changes in my circumstances that may affect support action in my case.

I certify that I have received a copy of DHS Publication 748, "Understanding Child Support, A Handbook for Parents."

Authorities:

45 CFR 302.33 Completion: **Application is voluntary for non-assistance applicants.**

R 400.3009 MAC and R 400.5008 MAC Failure to complete may result in loss of benefits from Child Development and Care (CDC) and the Food Assistance Program (FAP). Current FAP and CDC recipients are not required to sign the form.

42 USC 654(29) Failure to provide information may result in loss of Family Independence Program (FIP) benefits for all family members and loss of Medicaid (MA) for all adult members.

Applicant's Signature (Signature is Required) Date

Applicant's Printed Name

Michigan Department of Health and Human Services (MDHHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an MDHHS office in your area.

This institution is an equal opportunity provider.

Return completed application to:

Michigan Office of Child Support
Central Functions Unit
P.O. Box 30744
Lansing, MI 48909