

APPLICATION FOR CHILD SUPPORT SERVICES

- Check this space if you are the custodial parent. Custodial parent includes the physical custodian.
- Check this space if you are the putative (alleged) father or the noncustodial parent.

FOR OFFICE USE ONLY	
IV-D Number	_____
Date Requested	_____
Date Provided	_____
Date Returned	_____

Full child support services will be provided to you unless you check one of the two spaces shown below:

- I wish to receive only location services. Location Only Case - State Parent Locator Section (SPLS) I wish to receive only location services. Parental Kidnapping Case — SPLS
- No other service will be provided by child support staff when you request only location services.

1. NONCUSTODIAL PARENT'S NCP INFORMATION

Name (First Name, Middle Name, Last Name, Suffix)		Social Security Number:			
Noncustodial Parent's Maiden Name, if applicable (First Name, Middle Name, Last Name)					
Alias(es) (First Name, Middle Name, Last Name)			Nickname(s) (First Name, Middle Name, Last Name)		
Email Address					
Current Residential Address Street Number & Name Apt/Suite Number City State Country Zip Code			Previous Address Street Number & Name Apt/Suite Number City State Country Zip Code		
Current Mailing Address (Enter if the Noncustodial Parent has a different Mailing Address) Street Number & Name Apt/Suite Number City State Country Zi Code			Date last at that address:		
Home Telephone Number		Work Telephone Number		Cell Phone Number	
Sex: M____ F____	Date of Birth	Country of Birth	State of Birth	County of Birth	City of Birth
Race: <input type="checkbox"/> Native American or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other					
Hair Color	Eye Color	Weight	Height	Other Identifying Features	

What is the legal relationship status of Noncustodial Parent to child(ren)? (ex. Legal Father, Alleged Putative Father etc.) .			
What is employment status of the Noncustodial Parent?) Full Time		Part Time () Unemployed () Unknown () Seasonal	
Current Employer Name Address Street Number & Name Apt/Suite Number City State Country Zip Code Start Date Salary _____ per		Previous Employer Name Address Street Number & Name Apt/Suite Number City State Country Zip Code Start Date End Date End Date _____ Per	
How often is the NCP paid?			
Occupation			
Union Name Union Number Address, if known Apt/Suite Number City State Country Zip Code		Military Branch: Dates: (From) _____ (To) _____	
Arrest/Prison Record In which state did this occur? In which county did this occur? Which facility?		Incarceration Date Release Date	
What is the current marital status of the NCP?			
Divorced () Married Never Married () Separated () Widowed			
Name of Noncustodial Parent's current spouse: (First Name, Middle Name, Last Name)			
Is the NCP currently receiving benefits? If so, select all that apply and list the state when applicable.			
() Medical Assistance State: _____ () RSDI/SSD _____ () SSI _____ () Food Stamps (SNAP) State: _____ () Black Lung _____ () Veterans Assistance _____ () TANF (AFDC/KTAP) State: _____ () Other : _____ () Child Care Assistance State: _____ () None : _____			
If the NCP is not currently receiving benefits, have benefits been received in the past? If so, select all that apply and list the state when applicable.			
() Medical Assistance State: _____ () RSDI/SSD _____ () SSI _____ () Food Stamps (SNAP) State: _____ () Black Lung _____ () Veterans Assistance _____ () TANF (AFDC/KTAP) State: _____ () Other : _____ () Child Care Assistance State: _____ () None : _____			
Does the Noncustodial Parent own a car? () Yes () No		Make	Model
			Year

NCP's Father's name (First Name, Middle Initial, Last Name)		NCP's Mother's name (First Name, Middle Initial, Last Name)	
		NCP's Mother's Maiden Name	
Is NCP's father livin ?	Yes (<input type="checkbox"/>) Unknown	Is NCP's mother living?	(<input type="checkbox"/>) Yes (<input type="checkbox"/>) No (<input type="checkbox"/>) Unknown
Father's Address (if known)? Street Number & Name Apt/Suite Number City State Country Zip Code Home Telephone Number: -		Mother' s Address (if known)? Street Number & Name Apt/Suite Number City State Country Zip Code Home Telephone Number: (

11. CUSTODIAL PARENT'S CP INFORMATION

Name (First Name, Middle Name, Last Name, Suffix)			Social Security Number:		
Custodial Parent's Maiden Name, if applicable (First Name, Middle Name, Last Name)					
Alias(es) (First Name, Middle Name, Last Name)			Nickname(s) (First Name, Middle Name, Last Name)		
Email Address					
Current Residential Address Street Number & Name Apt/Suite Number City State Country Zip Code			Current Mailing Address(Enter if the CP has a different mailing Address) Street Number & Name Apt/Suite Number City State Country Zip Code		
Home Telephone Number		Work Telephone Number		Cell Phone Number	
Sex: M____F____	Date of Birth	Country of Birth	State of Birth	County of Birth	City of Birth
Race: (<input type="checkbox"/>) Native American or Alaskan Native (<input type="checkbox"/>) Asian (<input type="checkbox"/>) Black or African American (<input type="checkbox"/>) Hispanic (<input type="checkbox"/>) Native Hawaiian or Other Pacific Islander (<input type="checkbox"/>) White(<input type="checkbox"/>) Unknown (<input type="checkbox"/>) Other					
Hair Color	Eye Color	Weight	Height	Other Identifying Features	
What is the legal relationship status of CP to child(ren)? (ex. Mother, Father, Grandmother, Grandfather etc.).					
What is employment status of the CP? (<input type="checkbox"/>) Full Time (<input type="checkbox"/>) Part Time (<input type="checkbox"/>) Unemployed (<input type="checkbox"/>) Unknown (<input type="checkbox"/>) Seasonal					
Current Employer Name Address Street Number & Name Apt/Suite Number City State Country Zip Code Start Date Salary			Previous Employer Name Address Street Number & Name Apt/Suite Number City State Country Zip Code Start Date End Date Ending Pay Per		

How often is the CP paid?	
Occupation	
Union Name Union Number Address, if known Apt/Suite Number City State Country Zip Code	Military Branch: Dates: (From) (To)
What is the current marital status of the CP? <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Name of CP's current spouse: (First Name, Middle Name, Last Name)	

Is the CP currently receiving benefits? If so, select all that apply and list the state when applicable.

Medical Assistance State: _____ RSDI SSI SSI
 Food Stamps (SNAP) State: _____ Black Lung Veterans Assistance
 TANF (AFDC/KTAP) State: _____ Other : _____
 Child Care Assistance State: _____ None : _____

If the CP is not currently receiving benefits, have benefits been received in the past? If so, select all that apply and list the state when applicable.

Medical Assistance State: _____ RSDI SSD SSI
 Food Stamps (SNAP) State: _____ Black Lung Veterans Assistance
 TANF (AFDC/KTAP) State: _____ Other : _____
 Child Care Assistance State: _____ None : _____

111. CHILD(REN)'S INFORMATION

Enter information about the child ren for whom services are being requested. Child — 1、

Complete Name (First Name, Middle Name, Last Name, Suffix)	Social Security Number:
Date of Birth	Sex: M
Race: <input type="checkbox"/> Native American or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Hispanic <input type="checkbox"/> Other	
State where child conceived	Place of Birth
Country of Birth State of Birth	Country of Birth City of Birth
Was the mother married when this child was conceived? (Yes/No)	
What is the name of the person to whom the mother was married?	
Was the child emancipated or married? (Yes/No)	
Is this child currently receiving benefits? If so, select all that apply and list the state when applicable.	
<input type="checkbox"/> Medical Assistance State: _____ <input type="checkbox"/> RSDI/SSD <input type="checkbox"/> TANF State: _____ <input type="checkbox"/> SSI <input type="checkbox"/> Food Stamps State: _____ <input type="checkbox"/> Veterans Assistance <input type="checkbox"/> Child Care Assistance State: _____ <input type="checkbox"/> Other	
Has this child previously received any benefits? If so, select all that apply and list the state when applicable.	
<input type="checkbox"/> Medical Assistance State: _____ <input type="checkbox"/> RSDI/SSD <input type="checkbox"/> TANF State: _____ <input type="checkbox"/> SSI <input type="checkbox"/> Food Stamps State: _____ <input type="checkbox"/> Veterans Assistance <input type="checkbox"/> Child Care Assistance State: _____ <input type="checkbox"/> Other	

Enter information about the child ren for whom services are being requested. Child — 2、

Complete Name (First Name, Middle Name, Last Name, Suffix)		Social Security Number:	
Date of Birth		Sex: M	
Race: <input type="checkbox"/> Native American or Alaskan Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Hispanic <input type="checkbox"/> Other	
State where child conceived		Place of Birth	
Count of Birth	State of Birth	Coun of Birth	Ci of Birth
Was the mother married when this child was conceived? (Yes/No)			
What is the name of the rson to whom the mother was married?			
Was the child emanci ated or married? (Yes/No)			
Is this child currently receiving benefits? If so, select all that apply and list the state when applicable.			
<input type="checkbox"/> Medical Assistance	State:	<input type="checkbox"/> RSDI/SSD	
<input type="checkbox"/> TANF	State:	<input type="checkbox"/> SSI	
<input type="checkbox"/> Food Stamps	State:	<input type="checkbox"/> Veterans Assistance	
<input type="checkbox"/> Child Care Assistance	State:	<input type="checkbox"/> Other	
Has this child previously received any benefits? If so, select all that apply and list the state when applicable.			
<input type="checkbox"/> Medical Assistance	State:	<input type="checkbox"/> RSDI/SSD	
<input type="checkbox"/> TANF	State:	<input type="checkbox"/> SSI	
<input type="checkbox"/> Food Stamps State: <input type="checkbox"/> Veterans Assistance <input type="checkbox"/> Child Care Assistance State: <input type="checkbox"/> Other .			

Enter information about the child ren for whom services are bein re uested. Child — 3 .

Complete Name (First Name, Middle Name, Last Name, Suffix)		Social Security Number:	
Date of Birth		Sex: M	
Race: <input type="checkbox"/> Native American or Alaskan Native or Other Pacific Islander		<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Hispanic <input type="checkbox"/> Other	
State where child conceived		Place of Birth	
Count of Birth	State of Birth	Count of Birth	Cit of Birth
Was the mother married when this child was conceived? (Yes/No)			
What is the name of the erson to whom the mother was married?			
Was the child emanci ated or married? (Yes/No)			
Is this child currently receiving benefits? If so, select all that apply and list the state when applicable.			
<input type="checkbox"/> Medical Assistance	State:	<input type="checkbox"/> RSDI/SSD	
<input type="checkbox"/> TANF	State:	<input type="checkbox"/> SSI	
<input type="checkbox"/> Food Stamps	State:	<input type="checkbox"/> Veterans Assistance	
<input type="checkbox"/> Child Care Assistance	State:	<input type="checkbox"/> Other	
Has this child previously received any benefits? If so, select all that apply and list the state when applicable.			
<input type="checkbox"/> Medical Assistance	State:	<input type="checkbox"/> RSDI/SSD	
<input type="checkbox"/> TANF	State:	<input type="checkbox"/> SSI	
<input type="checkbox"/> Food Stamps	State:	<input type="checkbox"/> Veterans Assistance	
<input type="checkbox"/> Child Care Assistance	State:	<input type="checkbox"/> Other	

Enter information about the child ren for whom services are bein re uested. Child — 4 .

Complete Name (First Name, Middle Name, Last name, Suffix)		Social Security Number:	
Date of Birth		Sex: M	
Race: <input type="checkbox"/> Native American or Alaskan Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Hispanic <input type="checkbox"/> Other	

State where child conceived		Place of Birth	
Count of Birth	State of Birth	Coun of Birth	Cit of Birth
Was the mother married when this child was conceived? (Yes/No			
What is the name of the erson to whom the mother was married?			
Was the child emancipated or married? (Yes/No			
Is this child currently receiving benefits? If so, select all that apply and list the state when applicable.			
<input type="checkbox"/> Medical Assistance	State:	<input type="checkbox"/> RSDI/SSD	
<input type="checkbox"/> TANF	State:	<input type="checkbox"/> SSI	
<input type="checkbox"/> Food Stamps	State:	<input type="checkbox"/> Veterans Assistance	
<input type="checkbox"/> Child Care Assistance	State:	<input type="checkbox"/> Other	
Has this child previously received any benefits? If so, select all that apply and list the state when applicable.			
<input type="checkbox"/> Medical Assistance	State:	<input type="checkbox"/> RSDI/SSD	
<input type="checkbox"/> TANF	State:	<input type="checkbox"/> SSI	
<input type="checkbox"/> Food Stamps	State:	<input type="checkbox"/> Veterans Assistance	
<input type="checkbox"/> Child Care Assistance	State:	<input type="checkbox"/> Other	

*Add page for additional children.

IV. BACKGROUND INFORMATION

Answer whether ou are the utative father, noncustodial arent, or the custodial arent.

Why is the NCP absent?	<input type="checkbox"/> Desertion	<input type="checkbox"/> Divorce	<input type="checkbox"/> Separation	<input type="checkbox"/> Parents Not Married
If the children's arents were married, on what date were the married?	Date:			
When were the children's arents last together?	Date:			
If the children •s parents are divorced, when and where were they divorced?				
Date	Country	State	County	City
If the parents were not married has paternity been established? <input type="checkbox"/> Yes				
If yes, when and where?				
Date	Country	State	Count	Ci
Have you previously requested (or) received Child Support Services for this child(REN)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, when and where?				
Date	Country	State	County	City
Has the noncustodial parent paid any medical expenses for the child(ren)? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown				
Has the noncustodial parent shared in the child(ren)'s support? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				

V. COURT ORDER INFORMATION (Attach co of an and all orders and/or affidavit of aterni)

Is there currently a child or medical support order for the child(ren)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, enter Information from most recent order				
Date of Order	Country	State	Count	Cit
Child Su ort order amount S	er			
Medical sup ort ordered?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Are there any prior child support orders? <input type="checkbox"/> Yes				

VI. MEDICAL SUPPORT INFORMATION

Is the child(ren) covered by medical insurance? <input type="checkbox"/> Yes If yes, who is providing coverage? <input type="checkbox"/> No							
<input type="checkbox"/> NCP	<input type="checkbox"/> Commonwealth of Kentucky						
<input type="checkbox"/> Other Name: _____ SSN: _____ <input type="checkbox"/> No							
If no, is medical insurance available? <input type="checkbox"/> Yes							
Name of the Com any:							
Address Apt/Suite Number, City State Zi Code							
Polic Number:							
Polic Effective Date:							
T es of Coverage							
<input type="checkbox"/> Hos ital	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Dru s	<input type="checkbox"/> Cancer Onl	<input type="checkbox"/> VA Health Benefits	<input type="checkbox"/> Other (Accident/Casualt)
Attach a co of Medical Insurance Card (Front + Back)							

Mail the completed form to:

Office Address

I certify under penalty of law that the information I have provided is true to the best of my knowledge and belief and that the services I have requested are for the sole purpose of establishing paternity, if needed; obtaining and enforcing a support obligation; or requesting a modification review according to the Kentucky Child Support Guidelines. I understand that child support services will be provided based on the best interest of the child(ren) listed on this application. I agree to inform the area child support office or the IV-D contracting official's office to which I am providing this application of any changes in the information submitted on this application. I also understand as explained to me in the Authorization and Acknowledgment of No Legal Representation (Form CS-11), which I have signed, the IV-D Contracting Officials employed by the Cabinet for Health and Family Services represent the state and not me, and that an attorney-client relationship does not exist between any of the IV-D Contracting Officials and me. I further understand that the Cabinet for Health and Family Services will assess a nonrefundable annual fee of \$35.00 for child support services when \$550.00 has been disbursed during the federal fiscal year.

SIGNATURE _____ DATE _____

Complete the entire form carefully and accurately. Incorrect information will delay the processing of your application.

INFORMATION ABOUT THE KENTUCKY CHILD SUPPORT PROGRAM

Available Services:

- Location of noncustodial parents.
- Establishment of paternity.
- Establishment of child/medical support orders.

- Enforcement of child/medical support orders.
- Collection and disbursement of current and/or past-due child/medical support obligations. ■ Enforcement and collection of spousal support when there is an existing spousal support order, the spouse or ex-spouse is living with the child, and CHFS is collecting support for the child.
- Review for possible modification of child/medical support obligations.
- Case closure if we are unable to contact you for 60 days. ■ Termination of support order.

Rights:

- All parties to the child support cases have equal status.
- Any party to the case can ask questions, raise issues, and request a review with or without assistance from an attorney.
- All parties have a right to have the support order reviewed every 36 months or sooner if there are on-going changes that cause a 15% increase or decrease in the support obligation amount.

Responsibilities:

- The applicant must provide complete and accurate information regarding yourself, the other parent, and the child(ren).
- You must notify us when your address changes.

State Fees:

- An annual fee of \$35.00 is collected from the applicant after \$550.00 has been collected within the Federal fiscal year.

Distribution Policy:

- CSE requires custodial parents to receive their child support payments by electronic deposit to a checking or savings account or prepaid debit card.
- CSE is required to distribute payments received within two (2) working days of receipt of the payment.

KEEP THIS PAGE FOR YOUR RECORDS****

COMMONWEALTH OF KENTUCKY
 Cabinet for Health and Family Services
 Department for Income Support
 Child Support Enforcement

cs-202
 (R. 2/17)
 921 KAR 1:380

AUTHORIZATION FOR ELECTRONIC DEPOSIT OF CHILD SUPPORT PAYMENTS

Custodial parents must choose to receive their child support payments by electronic deposit to a checking or savings account or prepaid (reloadable) debit card obtained by the custodial parent. Please complete this form and return to the address or fax number listed below to ensure timely receipt of your child support payments. Child support system records will be updated to match the address, telephone number and financial account information provided below.

Date:		Social Security Number of Custodial Parent:	
Name of Custodial Parent:		Telephone Number: (
Mailing Address of Custodial Parent:			
City:	State:	ZIP Code:	
I would like to receive my child support payments by (choose only one):			
Checkin Account	[2 Savin s Account	Pr aid (reloadable)Debit Card	
<p>*If you select the prepaid (reloadable) debit card option, call the telephone number or visit the website provided on the instructions that came with the card or that is listed on the back of the card to locate the routing number and account number for the prepaid (reloadable) debit card you obtained. The Child Support Enforcement agency cannot process this form without this information.</p>			
Name and address of Financial Institution (bank, credit union, etc):		Telephone Number of Financial Institution:	
		Account Number:	
		Routing Number: (this is a 9 digit number)	

I hereby authorize Child Support Enforcement (CSE) to deposit my child support payments to the account above and agree to the following conditions:

- If all information provided above is correct and complete, deposit of my child support payments into this account will begin within one week. If all information provided above is not correct and complete, deposit of my child support payments into this account will be delayed. All child support payments will be deposited to this account regardless of the number of child support cases I may have open in the State of Kentucky. I must allow two to three working days from the date the CSE Agency disbursed the payment to have the funds available in my account. I authorize CSE to adjust any overpayment made to my account. If funds are returned by the Financial Institution for any reason, CSE will hold those funds. CSE will attempt to contact me to obtain new account information but will not release the funds until new account information is received. It is my responsibility to keep CSE informed of my most recent mailing address and telephone number.
- No separate notice will be sent to me when child support payments are deposited into this account. I can obtain payment information 24 hours a day, 7 days a week by calling (800) 443-1576 or accessing the Kentucky Child Support Interactive (KCSI) website at <https://csws.chfs.ky.gov/csws/>.
- It is my responsibility to immediately notify CSE and complete a new authorization form when my account information changes. If I close my child support case, the account information on file at the time I closed my case will remain in effect until I complete a new authorization form. I can make changes to my account information electronically through the KCSI website at <https://csws.chfs.ky.gov/csws/> by

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Income Support
Child Support Enforcement

downloading the authorization form from this website, or obtaining it from my local CSE office and returning it to the address or fax number provided below.

I must return this form by fax to (502) 564-7938 or mail to Child Support Enforcement, Attn: EFT Coordinator, P.O. Box 2150 Frankfort, Kentucky 40602-2150.

Printed Name of Custodial Parent

Signature of Custodial Parent

Web site: <http://chfs.ky.gov/dis/cse.htm> • An Equal Opportunity Employer M/F/D

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cs-200
(R. 6/12)

AFFIDAVIT AND REQUEST FOR NONDISCLOSURE

If you feel that the health, safety and liberty of you or your child(ren) would be unreasonably put at risk by the release of your address or other identifying information, please complete this affidavit, sign in front of a notary and forward to the child support office handling your case.

IV-D#:

Custodial Parent: Noncustodial Parent:

_____, I, state under penalty of perjury that the disclosure of my address or other information identifying my location could be harmful to child(ren) under this IV-D number or to me. I am requesting that my address or other identifying information or that of the child(ren) not be disclosed to the other party in the case referenced above. This request for nondisclosure of information will remain in effect until I notify Kentucky Child Support Enforcement, in writing that the at-risk situation is no longer valid. I understand my request for nondisclosure may be subject to judicial review.

Please check all that apply:

- 1. A domestic violence protective order or restraining order has been issued against the other party.
- 2. The other party has been charged with a crime (such as assault or harassment) or been involved in a criminal civil or criminal court case in which I was a party, a victim, a witness, or otherwise involved.
- 3. Attached are medical records, police records, court reports, psychological reports, or other evidence demonstrating that an actual danger exists.
- 4. Other.

If you checked any of the above please explain what happened, when, where and who was involved:

Subscribed and Sworn to me _____
this day of _____, _____.
Notary _____ My Commission expires _____

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Income Support
Child Support Enforcement

I understand that this information may be shared with the Division of Family Support and Division of Protection and Permanency. I also understand that I am not legally represented by a CHFS attorney, and I have been advised to consult my own attorney concerning my legal rights.

Signature

Date

Street and Apt No.

Signed

City, State, Zip Code

(daytime telephone number or contact number)

Child Support Enforcement

Telephone:

CS-140

(R. 10/12)

921 KAR 1:380

ASSIGNMENT OF RIGHTS AND AUTHORIZATION TO COLLECT SUPPORT

Noncustodial Parent:

Child(ren):

IV-D Number:

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Income Support
Child Support Enforcement

_____, I, assign to the Cabinet for Health and Family Services (CHFS) medical support owed for the child not to exceed the amount of Medicaid payments made on behalf of the child.

I hereby authorize CHFS, to collect on my behalf all current and/or past-due child support, medical support and spousal support payable to me for the benefit of myself and/or my minor child(ren).

I authorize any and all current or past-due sums of child, medical and/or spousal support which are owed to me to be paid to CHFS and guarantee these monies have not already been paid.

I further understand that the Cabinet for Health and Family Services will assess a nonrefundable annual fee of \$35.00 for child support services when \$550.00 has been disbursed during the federal fiscal year.

CHFS shall distribute any and all payments received according to federal and state laws.

SIGNATURE

DATE

Return to:

Web
Employer WF/D

site:



<http://chfs.ky.gov/dis.cse.htm> Opportunity

Page 1 of 1

cs-11
(R. 10/12)
921 KAR 1:380

AUTHORIZATION AND ACKNOWLEDGEMENT OF NO LEGAL REPRESENTATION

Contracting Officials represent the Commonwealth of Kentucky, not you personally. If you apply for and use child support services through the Cabinet for Health and Family Services (CHFS), by signing below, you authorize and acknowledge the following:

- I request CHFS to assist me in my child support case, including court action, if necessary.

An Equal

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Income Support
Child Support Enforcement

- I acknowledge that any CHFS attorney to whom I may be referred will be dealing with me only in my capacity as the adult representative (guardian, custodial parent) pursuant to his or her obligation to provide legal services to and for CHFS and the Commonwealth of Kentucky according to KRS 205.712(7).
- I understand I am not legally represented by a CHFS attorney and a CHFS attorney may take a position unfavorable to me.
- I understand an attorney-client relationship does not exist between CHFS's attorney and me, and I understand the consequences of this on the issues of confidentiality and attorney-client privilege.
- I understand I have the right to obtain legal representation for myself at any time I choose, now or in the future, and I will be responsible for attorney fees and costs. If I choose private legal representation, I will notify the contracting official's office.
- I understand that information I provide to CHFS is not completely confidential. It is sometimes necessary for CHFS to provide information from its files to other people who work with CHFS to establish, enforce or modify child support orders. In addition, CHFS may provide information to appropriate authorities for use in the investigation and prosecution of welfare fraud or other violations of state or federal law. Also, the court may require the release of information to the noncustodial parent(s).

Signature

Date

DO NOT WRITE IN THIS SPACE

FOR AGENCY USE ONLY: IV-D NUMBER:

NONCUSTODIAL PARENT:

CUSTODIAL PARENT:

CHILD(REN):

THIRD PARTY AUTHORIZATION TO DISCUSS CASE

My name is: _____

My social security number is: _____

My telephone number is: _____ My

address is: _____

Federal and state laws limit the Warren County Child Support Office's ability to discuss information about a case with anyone other than a party to that case, unless a party authorizes in writing the release of information.

Parties granted third party authorization to discuss the case with our office have no rights to the information and information released shall be discretionary and limited in nature.

I, _____ hereby grant authorization for _____ to discuss my case with the Warren County Child Support Office.

PERSON TO AUTHORIZATION IS GRANTED TO DISCUSS CASE:

Name/Relation:

Address:

Telephone Number:

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO UPDATE THIS FORM. PROMPTLY WITH THE WARREN COUNTY CHILD SUPPORT OFFICE SHOULD A CHANGE IN CIRCUMSTANCES OCCUR. UNTIL I CHANGE THIS FORM AND REVOKE THE ABILITY TO SPEAK TO THE ABOVE NAMED PERSON THE DIVISION OF CHILD SUPPORT MAY CONTINUE TO SPEAK TO THE PERSON LISTED.

SIGNATURE

Subscribed and sworn to before me this _____ day of _____ 20____

NOTARY PUBLIC

MY COMMISSION EXPIRES: _____

*****FOR OFFICE USE ONLY*****

IVD: _____

DATE RECEIVED: _____

CASEWORKER: _____