

Office of the Attorney General – Child Support Enforcement Division

NON-CUSTODIAL PARENT

APPLICATION FOR CHILD SUPPORT SERVICES

IF YOU NEED ASSISTANCE IN COMPLETING THIS FORM, PLEASE CALL OUR OFFICE AT (671) 475-3360

**I. INFORMATION ABOUT THE INDIVIDUAL WHO HAS CUSTODY OF THE CHILD(REN)**

**(Please print all information)**

NAME (Last, First, MI)		List any other name used by custodial parent (Last, First, MI)			Relationship to Child(ren)	
Mailing Address			City	State	ZIP Code	
Street Address		City	State	ZIP Code	Telephone Number	
Current Employer		Date Employed	Earnings \$ _____ per _____		Telephone Number	
Street Address			City	State	ZIP Code	
Date of Birth	Birthplace (City, State)		Social Security Number		Driver's License or ID Number (include State)	
Sex	Race	Height	Weight	Hair Color	Eye Color	
List any physical or mental impairments, medical problems, etc.						
List any identifying scars, marks or tattoos						
Do you have a picture of the custodial parent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please attach.					Approximate Birth Year	
Vehicle Year	Vehicle Make	Vehicle Model	Vehicle Color	Vehicle License No.	State	
What is the custodial parent's marital status? <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Single						
Name of Current Spouse				Date of Marriage or Divorce		

**II. INFORMATION ABOUT YOU (Non-Custodial Parent)**

**(Please print all information)**

NAME (Last, First, MI)		Any other names by which you are known (Last, First, MI)			Relationship to Child(ren)	
Present Address	Apt. No.	City	State	ZIP Code	County	Telephone No.
Current Employer		Date Employed	Earnings \$ _____ per _____			
Street Address		City	State	ZIP Code	Telephone No.	
Previous Employer		Dates of Employment From: _____ to _____		Earnings \$ _____ per _____		
Street Address		City	State	ZIP Code	Telephone No.	
Date of Birth	Birthplace (City, State)		Social Security Number		Driver's License or ID Number (include State)	

**II. INFORMATION ABOUT YOU (Non-Custodial Parent)**

**(Please print all information)**

Sex	Race	Height	Weight	Hair Color	Eye Color
List any physical or mental impairments, medical problems, etc.					
Language Preference:			List any identifying scars, marks or tattoos		
Do you have a picture of yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please attach.				Age	

- Do you have any benefits? (food stamps, AFDC, Retirement, Worker's Compensation, Social Security Benefits, Unemployment Benefits, etc)  
 Yes  No If yes, what type of benefits? \_\_\_\_\_
- Other income, e.g., rent interest, other jobs, and dividends, trust?  
 Yes  No If yes, type of other income \_\_\_\_\_ Amount \$ \_\_\_\_\_ per \_\_\_\_\_
- Other Assets? Checking Account No. \_\_\_\_\_ Bank/Branch \_\_\_\_\_  
 Savings Account No. \_\_\_\_\_ Bank/Branch \_\_\_\_\_  
 Bonds \_\_\_\_\_
- Vehicle

Vehicle Year	Vehicle Make	Vehicle Model	Vehicle Color	Vehicle License No.	State

- My principle reason for applying for services is to obtain:
  - Paternity Services
  - Establishment of Court Ordered Child Support Obligation
  - Establishment of Medical Support
  - Review and Adjustment Services
  - Wage Assignment
- Do you own any land or have any substantial property or assets?  Yes  No If yes, list below:  
 Real Estate: \_\_\_\_\_ Registered Vehicles (other than the one listed above): \_\_\_\_\_

- List two persons through whom you can always be contacted:
 

Relationship to you	Name	Telephone Number
Address	City	State ZIP Code
Relationship to you	Name	Telephone Number
Address	City	State ZIP Code

- Do you have another attorney or agency helping you with your child support case?  Yes  No If yes, list the name of agency or attorney and address:  
 \_\_\_\_\_

**II. LIST THE CHILDREN SUBJECT TO THIS APPLICATION**

**(Please print all information)**

<b>1. Name (Last, First, MI)</b>			Date of Birth	Place of Birth (City, State)
Social Security Number	Sex	List any physical or mental impairments, medical problems, etc.	With whom does the child live?	
<b>2. Name (Last, First, MI)</b>			Date of Birth	Place of Birth (City, State)
Social Security Number	Sex	List any physical or mental impairments, medical problems, etc.	With whom does the child live?	
<b>3. Name (Last, First, MI)</b>			Date of Birth	Place of Birth (City, State)
Social Security Number	Sex	List any physical or mental impairments, medical problems, etc.	With whom does the child live?	
<b>4. Name (Last, First, MI)</b>			Date of Birth	Place of Birth (City, State)
Social Security Number	Sex	List any physical or mental impairments, medical problems, etc.	With whom does the child live?	
<b>5. Name (Last, First, MI)</b>			Date of Birth	Place of Birth (City, State)
Social Security Number	Sex	List any physical or mental impairments, medical problems, etc.	With whom does the child live?	
<b>6. Name (Last, First, MI)</b>			Date of Birth	Place of Birth (City, State)
Social Security Number	Sex	List any physical or mental impairments, medical problems, etc.	With whom does the child live?	
<b>7. Name (Last, First, MI)</b>			Date of Birth	Place of Birth (City, State)
Social Security Number	Sex	List any physical or mental impairments, medical problems, etc.	With whom does the child live?	
<b>8. Name (Last, First, MI)</b>			Date of Birth	Place of Birth (City, State)
Social Security Number	Sex	List any physical or mental impairments, medical problems, etc.	With whom does the child live?	
<b>9. Name (Last, First, MI)</b>			Date of Birth	Place of Birth (City, State)
Social Security Number	Sex	List any physical or mental impairments, medical problems, etc.	With whom does the child live?	
<b>10. Name (Last, First, MI)</b>			Date of Birth	Place of Birth (City, State)
Social Security Number	Sex	List any physical or mental impairments, medical problems, etc.	With whom does the child live?	

**III. LIST THE CHILDREN SUBJECT TO THIS APPLICATION (continued)**

11. Are all the children listed above enrolled in a health plan?  Yes  No If no, which children are enrolled?  
\_\_\_\_\_
12. Who is the provider of the health insurance? \_\_\_\_\_
13. What is the cost to cover your child(ren)? List amount \$\_\_\_\_\_ per \_\_\_\_\_ Enrollment date \_\_\_\_\_
14. Name of Insurance company \_\_\_\_\_
15. Address of insurance company \_\_\_\_\_
16. Health Insurance Group Number \_\_\_\_\_ Health Insurance Policy Number \_\_\_\_\_

**IV. ADDITIONAL INFORMATION (please print all information)**

1. What is the current relationship between the mother and father of the children?  
 Never Married  Married/living apart Date of Marriage: \_\_\_\_\_ County: \_\_\_\_\_ ST: \_\_\_\_\_  
 Divorced
2. If you are divorced or have any court order (divorce order, paternity order, custody order, protective order, etc., of any kind regarding the children) please attach a copy of the order to this form. If you are unable to provide a copy you must provide the following:

Date	Case Number	County	State	Court

3. Are there any legal actions pending that affect the child(ren) listed above?  Yes  No If yes, please attach a copy of the pending legal action to this form. If you are unable to provide a copy you must provide the following:

Date	Case Number	County	State	Court

4. Attorney name and address: \_\_\_\_\_
5. Do you have other biological children under 18 years of age?  Yes  No If yes, how many? \_\_\_\_\_  
Please provide birth certificates for each child.
6. Are you ordered to pay child support for any child(ren) not listed above?  Yes  No If yes, enter the order information.  
 Case # \_\_\_\_\_ Count \_\_\_\_\_ State \_\_\_\_\_  
 \$ \_\_\_\_\_

CONDITIONS UNDER WHICH SERVICES ARE PROVIDED

1. Our attorneys represent the Territory of Guam in providing child support services, but do not represent you or any other individual. Title 5, Guam Code Annotated §34106(f).
2. The agency, in accordance with federal requirements, will determine which services and remedies are appropriate in each case. Title 5, Guam Code Annotated §34106(f).
3. Parents do not have the right “to dictate what enforcement actions are taken in the case.” 55 Fed. Reg. 156 (Aug. 15, 1990) @ 33418.
4. Applicants may not limit the services provided; in fact, the agency is required to provide all appropriate services for the benefit of the children. These services may include:
  - establishment of cash and medical support obligations
  - collection and distribution of child support payments
  - interception of I.R.S. refunds for child support
  - administrative or court-ordered wage withholding
  - reporting or arrearage to credit-reporting agencies
  - review and adjustment or child support orders (upward or downward) in accordance with child support guidelines
  - determination of arrearage and enforcement through court action, including contempt, if appropriate

**PLEASE NOTE:** Services provided pursuant to this application do not include location of the custodial parent.

5. All persons who receive child support services are required to cooperate with the agency in performing all required services.
6. Services may be terminated to non-public assistance recipients who fail to cooperate with actions required to provide services.
7. Non-public assistance recipients of services have a right to terminate services at any time; however, this right does not affect the right of the agency to complete any action already in progress, and does not prevent any other individual from applying for services.
8. Social security number information is necessary and may be used and released for various purposes (as authorized under 45 CFR, such as:
  - cataloging case files
  - submitting the case for federal and state income tax refund offset
  - enrolling the children in health insurance plans
9. The Office of the Attorney General does not charge a fee for services. However, if child support order is established, the person ordered to pay child support may also be responsible for paying certain other costs.

I want the services of the Office of the Attorney General, Child Support Enforcement Division.

The information in this application is true and complete. I have either read the information in this application packet or had it read to me. My signature is my agreement to the above statement and the statements included in this application packet.

\_\_\_\_\_  
(Applicant’s Signature)

\_\_\_\_\_  
(Date Signed)

\_\_\_\_\_  
(Social Security Number)