

Name of Custodial Party (First, Middle, Last, Maiden)		Name of Noncustodial Party (First, Middle, Last, Maiden)	
Social Security Number	Date of Birth	Social Security Number	Date of Birth
Custodial Party Address <input type="checkbox"/> Residence <input type="checkbox"/> Mailing		Noncustodial Party Address <input type="checkbox"/> Residence <input type="checkbox"/> Mailing	
Child's Biological Mother		Child's Biological Father	
Court Case Number		County and State in Which Court Case is Located	
Title of Court Case			
VS.			
Child's Full Name (First, Middle, Last)		Child's Social Security Number	Child's Date of Birth

Support Enforcement Services Include :

- Locating Parents;
- Establishing Paternity;
- Establishing Court Orders for Child Support;
- Establishing Court Orders for Medical Support;
- Enforcing Orders for Child, Spousal and Medical Support;
- Modifying Child Support Orders (Upon Request).

I understand that if I apply for child support enforcement services:

1. The IV-D (child support enforcement) agency will take any appropriate action to perform the services listed above. The IV-D agency includes the Department of Health & Human Services and county attorney or authorized attorneys and any contracted agent.
2. I may have to pay charges if services are provided by states or federal agencies that charge for their services.
3. The county attorney or authorized attorney is not my personal attorney, and an attorney-client relationship does not exist between the attorney and me.
 - a. Any legal action that is taken as a result of this application is at the discretion of the county attorney or authorized attorney.
 - b. There is not a privilege of confidentiality to me that would have otherwise existed as a result of an attorney-client relationship.
 - c. The county attorney or authorized attorney is working solely on behalf of the State.
 - d. The county attorney or authorized attorney cannot represent me in visitation, custody, or domestic relations issues if they arise.
4. I have an obligation to the IV-D agency to cooperate and my failure to cooperate may result in the closing of my case.
5. Support collected by the IV-D agency will be paid out according to State and Federal laws and rules.
6. Social security numbers obtained regarding the child(ren) may be used for establishment and/or enforcement of medical support.

By signing this form, I acknowledge that I have read, understand and agree to all the terms on the front and back of this application.

I would like to receive medical support establishment and/or enforcement services in addition to child support services.

Signature of Applicant

Date Application Signed

<p>For office use only: Date application request received: ____/____/____</p> <p>Date application sent to requestor: ____/____/____</p> <p>Date completed application received in office: ____/____/____</p>

A. Locating Parents: I understand it is my responsibility to cooperate in the identification and location of the other parent/party. This includes providing the IV-D agency with any information about the other parent/party's residence, employment, property and any other information that would be helpful.

B. Establishing Paternity: I understand that the IV-D agency will pursue establishment of paternity in all cases where it is necessary to obtain a support order. If there is more than one possible father, I must identify and assist in locating all alleged fathers. I may be required to appear with my minor child(ren) to provide blood and/or tissue samples for the purpose of genetic testing to establish paternity.

C. Establishing Court Orders for Child Support: I may be required to cooperate in the establishment of a support order (this does not include spousal support). I will appear and testify in court when requested to do so by the IV-D agency and will provide any financial information about myself or the other parent/party to the IV-D agency when it is requested.

D. Establishing Court Orders for Medical Support: I understand that I may request the IV-D agency to establish a medical support obligation. This obligation may include health insurance or medical support payments for specific dollar amounts, such as birth-related expenses. I may be required to provide the IV-D agency with information regarding medical insurance coverage and medical information regarding my child(ren) for the purpose of obtaining coverage. The child's Social Security Number may be used to enroll the child in health insurance coverage.

E. Enforcing Orders for Child, Spousal and Medical Support: I understand that I will be required to cooperate in the enforcement of any court-ordered support. I will appear and testify in court when requested to do so by the IV-D agency for the purpose of enforcing my support order.

I understand that my child/spousal support payments will be redirected to the Department of Health & Human Services if I have an out-of-state court order as long as I receive child support enforcement services. The support collected will be paid out according to State and Federal laws and rules.

I understand that the Department of Health & Human Services will submit the name of the parent/party ordered to pay support to the U.S. Department of Treasury, Internal Revenue Services (IRS) and Nebraska Department of Revenue to intercept his/her federal payments and/or tax refund(s) for delinquent support. I understand that any money owed to the federal government or to the State for ADC or Medicaid benefits will be paid before I receive money from the tax refund intercept. I understand that if the parent files a joint return, the Department of Health & Human Services may hold the tax refund up to six months. I understand that if the parent files an amended return (which could be up to 6 years after the tax year), or if the amount paid to me from the refund intercept is incorrect, I must pay back the amount owed to the Department of Health & Human Services.

F. Modifying Child Support Orders (Upon Request): I understand as a parent subject to a Nebraska child support court order, I may request the Child Support Enforcement Unit (CSEU) to review the dollar amount of the court order to determine if it is the proper amount according to the Nebraska Child Support Guidelines. Health insurance may be added to the order. To add health insurance, it must be available to the parent ordered to pay support through an employer or other organization. The children cannot presently be covered by health insurance other than Medicaid.

G. Disclosure of Nonrepresentation: I understand that when I give information to child support officials or the State's lawyer, that information may be used by the officials or the State's lawyer if it is necessary or appropriate. I will not be able to tell them that the information cannot be used. I will not be able to tell them how to use the information. The information can even be used against me in any of my child support cases or if I break the law.

I understand that because there is no attorney-client relationship between the State's lawyer and myself, if I violate any laws, the State's lawyer may prosecute me for those violations.

Date Received: (Date stamp area)

IV-D Case Number:		Date Mailed to Requestor:	
FOR OFFICE USE ONLY:			
IM Worker Number/Name:		Type of Case:	<input type="checkbox"/> ADC <input type="checkbox"/> Medical Only
Case Name:		PA Program Case Number:	
Names of Other Adults Living in the Home:			
1. _____ 2. _____			
<input type="checkbox"/> New <input type="checkbox"/> ReOpen			
Good Cause Claimed:		<input type="checkbox"/> Yes <input type="checkbox"/> No Non-Custodial Parent's Name: _____	
Good Cause Status:		<input type="checkbox"/> Pending <input type="checkbox"/> Accepted/Proceed <input type="checkbox"/> Accepted/Do Not Proceed <input type="checkbox"/> Denied Date _____	
Medicaid-Only Client Declines Child Support Enforcement Services:		<input type="checkbox"/> Yes <input type="checkbox"/> No	



**CUSTODIAL PARENT/CARETAKER RELATIVE
CHILD SUPPORT QUESTIONNAIRE**
Nebraska Department of Health and Human Services

**FORM
CSE0001a**

SECTION 1 INFORMATION ABOUT YOU				
Your Name (First, Middle, Last)		Date of Birth (Mo, Day, Year)	Sex (M/F)	Social Security Number
Maiden Name		Other Names Used		Race (Black, White, Asian, American Indian, Other)
Residence Address (Street)		City	State	Zip Code
Mailing Address		City	State	Zip Code
Home Phone Number ()	Other Phone Number Used ()	Whose phone is this? <input type="checkbox"/> Friend <input type="checkbox"/> Relative <input type="checkbox"/> Other Name: _____		
Emergency Contact Person's Name		Relationship to You		Phone Number ()
Employer's Name				Employer's Phone Number ()
Employer's Address (Street)		City	State	Zip Code
Current Occupation or Job Title				
Are you able to take calls at work? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what hours?			Work Phone Number ()	
Do You Speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, what language do you speak?				
List other adults living with you				
Name _____		Relationship to You _____		
_____		_____		



CUSTODIAL PARENT/CARETAKER RELATIVE CHILD SUPPORT QUESTIONNAIRE

Nebraska Department of Health and Human Services

FORM
 CSE0001b

SECTION 2 – INFORMATION ABOUT YOU (Skip Section 2 if you are a Caretaker Relative)

Other income sources: (Check all that Apply)

- Social Security Worker's Compensation Unemployment
 Public Assistance Veteran's Benefits Other (specify) _____

Have you ever received public assistance in another state?

- Yes No If yes, answer the following:

What Agency? _____

Where? (City, County, State) _____

When? (Month, Year) From: _____ To: _____

Which children were with you? (Give names)

Highest level you completed in school? (Check One)

- Less than High School High School Graduate
 Trade School/Some College College Graduate

Are you currently in school? Yes No If yes, give name and address of school:

Your Mother's Name (First, Middle, Last, Maiden)

Home Phone Number
 ()

Mother's Residence Address (Street)

City

State or Foreign Country

Zip Code

Your Father's Name (First, Middle, Last)

Home Phone Number
 ()

Father's Residence Address (Street)

City

State or Foreign Country

Zip Code

Your current Marital Status:

- Never Married Separated Married Divorced Widowed Other (specify) _____

If you are currently married or separated, answer the following:

Date of Marriage: (Month, Day, Year) _____

Place of Marriage: (City, County, and State or Foreign Country) _____

Spouse's Name: _____

Date of Separation: (Month, Day, Year)

Has a petition for divorce or legal separation been filed?

- Yes No If yes, answer the following:

When? (Month, Day, Year) _____

Where? (City, County, State) _____

Your Attorney's Name and Address:

Have you ever been married before?

- Yes No If yes, answer the following:

When? (Month, Day, Year) _____

Where? (City, County, State) _____

Spouse's Name: _____



CUSTODIAL PARENT/CARETAKER RELATIVE CHILD SUPPORT QUESTIONNAIRE

Nebraska Department of Health and Human Services

FORM
 CSE0001c

SECTION 3 DEPENDENT CHILD INFORMATION

Child's Name (First, Middle, Last)	Date of Birth (Mo, Day, Year) or Expected Date of Birth	Sex (M/F Unborn)	Social Security Number	Race (Black, White, Asian, American Indian, Other)
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What is the child's relationship to you?

<input type="checkbox"/> Natural Child	<input type="checkbox"/> Step Child	<input type="checkbox"/> Adopted Child	<input type="checkbox"/> Ward	<input type="checkbox"/> Foster Child
<input type="checkbox"/> Grandchild	<input type="checkbox"/> Niece/Nephew	<input type="checkbox"/> Sister/Brother	<input type="checkbox"/> Cousin	<input type="checkbox"/> Other (specify) _____

What is the child's relationship to the noncustodial parent?

<input type="checkbox"/> Natural Child	<input type="checkbox"/> Step Child	<input type="checkbox"/> Adopted Child	<input type="checkbox"/> Other (specify) _____
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Is this child covered by medical insurance? Yes No If yes, answer the following:

Policy Number: _____

Name of person providing coverage: _____

Name and Address of Insurance Company: _____

Child's Place of Birth (City, County, and State or Foreign Country) _____

Child's Mother's Name	Child's Legal Father's Name
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Child's Alleged Father's Name _____

Has the father been determined by legal action? Yes No If yes, how?

<input type="checkbox"/> By Marriage	<input type="checkbox"/> Written Acknowledgment	<input type="checkbox"/> Genetic Tests	<input type="checkbox"/> Court Order	<input type="checkbox"/> Other (specify) _____
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When did this legal action take place? (Month, Day, Year) _____

Whose name is on the child's birth certificate as the father? _____

COURT ORDER INFORMATION

Is there a court order for the noncustodial parent to support the above child? Yes No If yes, answer the following:

What is the court order number? _____

When was the order entered? (Month, Day, Year) _____

Where is the order for support? (City, County, State or Foreign Country) _____

Where does the noncustodial parent send the support payments? Directly to You To the Court Other (Specify) _____

Did the court order this person to provide medical insurance for the child? Yes No

Please attach a copy of the court order if it is not a Nebraska Order.

If there is not an order for child support in any court, does the noncustodial parent make any voluntary payments directly to you? Yes No

If yes, how much do you receive? \$ _____ per Week Month Other (specify) _____



CUSTODIAL PARENT/CARETAKER RELATIVE CHILD SUPPORT QUESTIONNAIRE

Nebraska Department of Health and Human Services

FORM
 CSE0001d

SECTION 4 INFORMATION ABOUT THE NONCUSTODIAL PARENT			
Noncustodial Parent's Name (First, Middle, Last)		Date of Birth (Mo, Day, Year)	Sex (M/F) Social Security Number
Maiden Name		Nicknames or Alias Names Used	
Height in Feet _____ Inches _____	Weight	Hair Color	Eye Color Race
Does this person have any distinguishing marks or characteristics? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:			
What is your relationship to this person? <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Other (Specify) _____			
Residence Address (Street)		City	State or Foreign Country Zip Code
Mailing Address		City	State or Foreign Country Zip Code
Previous Address <input type="checkbox"/> Residence <input type="checkbox"/> Mailing		City	State or Foreign Country Zip Code
Home Phone Number () () ()	Other Phone Number Used () () ()	Whose phone is this? <input type="checkbox"/> Friend <input type="checkbox"/> Relative <input type="checkbox"/> Other Name:	
Place of Birth (City, County, and State or Foreign Country)			
Is this person currently? <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____			
Most Recent Spouse's Name (other than you) _____			
Spouse's Address (Street, City, State) _____			
Does this person speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what language does he/she speak? _____			
Highest level this person completed in school? (Check One) <input type="checkbox"/> Less than high school <input type="checkbox"/> High school graduate <input type="checkbox"/> Trade school/some college <input type="checkbox"/> College graduate			
Is this person currently in school? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give name and address of school.			
Employer's Name			Employer's Phone Number () () ()
Employer's Address (Street)		City	State or Foreign Country Zip Code
Is the address listed above the work-site address? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know			
Payroll office address? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know			
Supervisor's Name		Supervisor's Phone Number () () ()	
What is this person's current occupation or job title?			
Does this person have medical insurance AVAILABLE through work or another organization? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know If yes,			
Employer or Organization Name _____			
Name and Address of Insurance Company _____			
Does this person CARRY medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the policy number? _____			

SECTION 4 (Continued)

INFORMATION ABOUT THE NONCUSTODIAL PARENT

Is/was this person in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know If yes, what branch?			
<input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Marine Corps <input type="checkbox"/> Coast Guard <input type="checkbox"/> Other (Specify) _____			
Current Military status?			
<input type="checkbox"/> Active Duty <input type="checkbox"/> Former Member (Discharged) <input type="checkbox"/> Retired <input type="checkbox"/> Reserve <input type="checkbox"/> Guard			
Does this person receive income from?(Check all that Apply):			
<input type="checkbox"/> Social Security		<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> Unemployment
<input type="checkbox"/> Veteran's Benefits		<input type="checkbox"/> Public Assistance	<input type="checkbox"/> Other (Specify) _____
What is this person's usual occupation?			
Does this person have any special training? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: (ex. Plumbing, Welding, Mechanic)			
Does this person have a driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify:			
License Number: _____		State: _____	
Does this person have any special licenses? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify:			
Type: _____		License Number: _____	State: _____
This person's Mother's Name (First, Middle, Last, Maiden)			Home Phone Number ()
Mother's Residence Address (Street)		City	State or Foreign Country Zip Code
This person's Father's Name (First, Middle, Last,)			Home Phone Number ()
Father's Residence Address (Street)		City	State or Foreign Country Zip Code
Does this person have any checking, savings, or IRA accounts? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know If yes, list below:			
Type of Account	Account Number		Name and Address of Institution
Does this person have any motor vehicles? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know If yes, list below: (ex. Car, Truck, Motorcycle, Boat, Plane)			
Make	Model	Year	Color Lic. Plate Number Other Description
Does this person have anything else of value? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know If yes, list below: (ex. Home, Land)			
Has this person ever been arrested? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know If yes, answer the following:			
What for?		When? (Month, Day, Year)	Where? (City, County, State)
Is this person currently in jail? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know If yes, where?			
Has this person ever been on probation or parole? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know If yes, answer the following			
What for?		When? (Month, Day, Year)	Where? (City, County, State)
Name, address, and phone number of probation or parole officer:			
When was the last contact you had with this person?(Month, Day, Year)			
Where was the last contact you had with this person?			
How was the last contact made? (ex. Phone, Letter, Face to Face)			
I hereby state that all answers to the questions in this form are true and complete to the best of my knowledge. Applicant's Signature			Date