APPLICATION FOR MODIFICATION OF CHILD SUPPORT

____
Mother's Name

Cause Number: ____________________
Case number: ______________

____
Father's Name

Please complete this application form, and submit it to our office along with your three (3) most recent paycheck stubs. If you receive unemployment or Social Security benefits, please provide a statement showing the amount of these benefits that you receive. If you do not provide this information, we cannot process your request for a modification.

Please be advised that your caseworker may ask for a complete copy of your most recent federal income tax return if needed.

1. Current Gross Employment Income:
   a. $____________ per week
   b. $ ____________ per month

2. Other Monthly Current Income Sources:
   a. Social Security Disability: $ ________
   b. SSI (Supplemental Security Income) $ ________________________
   c. Social Security Retirement $_________
   d. VA Benefits $_________
   e. TANF $ _______________________
   f. Worker's Compensation $_________
   g. Unemployment Benefits: $_________

3. **Other Monthly Current Income Received by your Child(ren):**
   a. SSI (due to child's disability) $ ________
   b. Social Security Dependency Benefit $_______________________
   (Direct benefits received by child as a result of parent's disability)

4. **If you are NOT currently employed, please provide the following for your last three (3) places of employment:**

Employer Name	Dates of Employment	Rate of Pay Per Hour	Reason for Leaving

5. Other persons living in your household:

Name	Birth Date	Relationship to You

6. Name of child(ren) on this case:

____

____

____

____

a. **Do you pay child care expenses for the child(ren) on this case?**
Yes ______ No ______

a. Child(ren)'s Name(s): ______________________________

b. Name of Provider: ______________________________

c. Weekly Amount Paid: ______________________________

b. **Do you carry health insurance for the child(ren) on this case?**
Yes ______ No ______

Do you have health insurance available to you for the child(ren) on this case?
Yes ______ No ______

a. **Name of Insurance Company:**

____

b. **Type of Insurance Coverage:**

i. Medical? ______ yes ______ no
ii. Dental? ______ yes ______ no
iii. Vision? ______ yes ______ no

c. If you carry health insurance, who is covered under your policy (including yourself)?

Name	Relationship to You

d. **If you carry health insurance, how much do you pay for your policy? Please note: You MUST provide cost for single AND family coverage in order to receive credit for what your pay for the child(ren), if not provided you will not receive credit.**

Cost for Single Medical Coverage: $____________/week
Cost for Family Medical Coverage: $____________/week

Cost for Single Dental Coverage: $____________/week
Cost of Family Dental Coverage: $____________/week

Cost for Single Vision Coverage: $____________/week
Cost for Family Vision Coverage: $____________/week

Cost for any other Coverage (Please specify type)

______________________________ $____________/week

e. **Do you pay child support for any other child(ren) besides the child(ren) on this case?**
Yes ______ No ______

Name of Child(ren)	Date of Birth	County/State of Order	Amount of Order

f. Does visitation occur with the child(ren) on this case?
Yes ______ No ______

If so, please check all that apply:

_______ Visitation occurs every other weekend.

_______ Visitation occurs every weekend.

_______ Overnight visitation occurs _____ times during the week (excluding weekends)

_______ Extended visitation occurs for ______ weeks during the summer.

_______ Other (please describe the visitation schedule in as much detail as possible):

____

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____

____

____

Please list the following information about yourself:

Name: ____

Address: ____

____

Telephone: ________________________

______________________________ ______________________________
Date **Signature**

(Revised 05/28/2019)