



# LAC COURTE OREILLES CHILD SUPPORT PROGRAM

## Application for Services

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13394W Trepania Rd.

Hayward, WI 54843

Phone: 715-634-8934 \* Fax: 715-634-0080

# APPLICATION FOR SERVICES

- Please fill out this application as completely as possible. If you have questions about this application or need assistance in completing it, please contact the LCO Child Support Program.
- There is no application charge for initial services, however if you request your case to be closed, an application charge of \$25 may apply if you request it to be re-opened at a later date.
- If you are unsure of information or do not know some of the information you can leave that portion blank.
- The more information you can provide the better job your child support worker can do on your case.
- PLEASE PRINT.

## SECTION 1: APPLICANT INFORMATION

This is the person applying for services. If Applicant is the Custodial Party it means the person with both legal custody, either sole or joint, and primary physical placement (the party with whom the child(ren) lives with most of the time).

**Applicant's Full Name:** \_\_\_\_\_

Your Relationship to Child(ren):  Mother  Father  Grandparent  Guardian  Other

If you are not the parent, give parent's names: Mother \_\_\_\_\_

Father \_\_\_\_\_

**If the children have different mothers or fathers, use a separate application for each absent parent.**

Do you have a disability?  Yes  No

If yes, describe: \_\_\_\_\_

### SERVICES REQUESTED: (Please check all that apply)

Federal regulations require the LCO Child Support Program to provide all services appropriate for your case based on your circumstances.

- |  |  |
|--|--|
| <input type="checkbox"/> Establish Paternity             | <input type="checkbox"/> Review Support Order (Modification Request) |
| <input type="checkbox"/> Establish Child Support Order   | <input type="checkbox"/> Establish Medical Support Order             |
| <input type="checkbox"/> Enforce (Collect) Child Support | <input type="checkbox"/> Locate Absent Parent                        |

In addition to the services listed above, Lac Courte Oreilles Child Support Program offers:

- The Grandparents Advisory Circle's Peacekeepers Council

**Please attach copies of any and all court orders, judgments, decrees or stipulations involving child support or child custody. Whenever there are changes in the information in the future, please send copies to the LCO Child Support Program.**

**For office use only:**

Date of Request: \_\_\_\_\_ Fees Due: \$ \_\_\_\_\_ Fees Waived:  Yes  No

Case Type:  IV-D  Non-IV-D  FIP/TANF  Food Stamps  Medicaid  Locate Only  
 Paternity Only  Inter-Jurisdictional Referral

**SECTION 2: CUSTODIAL PARTY (CP) INFORMATION**

Custodial Party's Name (Last, First, Middle, Suffix – Sr., Jr., etc.)				Maiden Name or Alias	
Social Security Number	Date of Birth	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	Tribal Affiliation / Enrollment Number	
Birth City		Birth County		Birth State	Birth Country
Home Phone		Work Phone		Cell Phone	
Physical Address					
City				State	Zip
Mailing Address ( <input type="checkbox"/> check if same as Physical Address)					
City				State	Zip
Member of Military? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, <input type="checkbox"/> Active <input type="checkbox"/> Retired		Branch:	
Date(s) of Service From: _____ To: _____			Do you receive Veteran's Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No		

If Applicant is Child(ren)'s parent, please check current marital status:  
 Married  Separated  Divorced  Widowed  Never Married

Current relationship to absent parent:

<input type="checkbox"/> Married	Date	State	County	City
<input type="checkbox"/> Separated	Date	State	County	City
<input type="checkbox"/> Divorced	Date	State	County	City
<input type="checkbox"/> Annulled	Date	State	County	City

<b>***IMPORTANT***</b>		
<b>If a child was conceived or born during a marriage, the law presumes that the husband is the legal father. If you were married at the time the child was conceived or born and believe that someone other than your husband may have been the father, provide information here. If you were not married, leave blank.</b>		
Name	Date of Birth	Social Security Number
Street Address	City	State / Zip

**SECTION 2: CUSTODIAL PARTY INFORMATION (cont.)**

Has the custodial party ever received any of the following:		
Child Support Services <input type="checkbox"/> Yes <input type="checkbox"/> No	State/Tribe received from:	Dates Received:
T.A.N.F./F.I.P. <input type="checkbox"/> Yes <input type="checkbox"/> No	State/Tribe received from:	Dates Received:
Food Stamps <input type="checkbox"/> Yes <input type="checkbox"/> No	State/Tribe received from:	Dates Received:
Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No	State/Tribe received from:	Dates Received:
Child Care <input type="checkbox"/> Yes <input type="checkbox"/> No	State/Tribe received from:	Dates Received:

**Custodial Party's Employment and Income**

Employer Name:				
Address:			State	Zip
Phone Number:		Fax Number:		
Your Start Date:	Job Title:	Hours Worked Per Week:	Hourly Pay Rate: \$	How often are you paid? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly
Do you have an Occupational/Professional License? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, type of license:		
Other sources of income: (describe, amount, and how often received)				

**SECTION 3: CHILD CARE INFORMATION**

Do you have child care Expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Names of children receiving child care:	
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	
Number of Hours per week for child care:	Cost per Hour: \$
Name, Address, Phone # of Child Care Provider: _____ _____ _____	Check reason for child care: <input type="checkbox"/> Work Related <input type="checkbox"/> Looking for Employment <input type="checkbox"/> Enrolled in educational program to improve employment opportunities.

**SECTION 4: NON-CUSTODIAL PARTY (NCP) INFORMATION**

This is the parent who is absent from the home and/or the alleged father. **Use separate form for each absent parent.**

<b>Non-Custodial Party's Name</b> (Last, First, Middle, Suffix – Sr., Jr., etc.)				Maiden Name or Alias	
Social Security Number (SSN)	Date of Birth (DOB)	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	Tribal Affiliation / Enrollment Number	
Birth City		Birth County		Birth State	Birth Country
Home Phone		Work Phone		Cell Phone	
Physical Address <input type="checkbox"/> Current <input type="checkbox"/> Last Known					
City				State	Zip
Mailing Address ( <input type="checkbox"/> check if same as Physical Address) <input type="checkbox"/> Current <input type="checkbox"/> Last Known					
City				State	Zip
Member of Military? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, <input type="checkbox"/> Active <input type="checkbox"/> Retired		Branch:	
Date(s) of Service: From: _____ To: _____			Do they receive Veteran's Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Distinguishing Marks (Tattoos, scars, birth marks, etc.)		Height	Weight	Eyes	Hair
Race					
Current Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown					
Mother's Maiden Name			Father's Name		
Has Non-Custodial Party ever been convicted of a crime? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date and Place of Arrest?		Probation/Parole Officer:	
Date(s) Non-Custodial Party lived in Custodial Party's household: From: _____ To: _____ City/State: _____					

Please provide any additional information you believe would be helpful to locate this person. Include names and addresses of friends or relatives who might know how to locate this person. Please include a picture of the person if possible.

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**SECTION 4: NON-CUSTODIAL PARTY (NCP) INFORMATION (cont.)**

<b>Non-Custodial Party's Employment and Income</b>					
Employer Name: _____					
Address: _____				State _____	Zip _____
Phone Number: _____			Fax Number: _____		
Start Date: _____	Job Title: _____	Hours worked per week: _____	Hourly pay Rate: \$ _____	How often are they paid? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly	
Does Non-Custodial Party have an Occupational/Professional License? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			If Yes, type of license: _____		
Health Insurance Available (check all that apply)  <input type="checkbox"/> Medical  <input type="checkbox"/> Dental  <input type="checkbox"/> Optical	List all persons covered by the Health Insurance: _____ _____ _____		Premium amount paid: \$ _____ Family Plan  \$ _____ Single Plan	Per:  <input type="checkbox"/> Pay Period <input type="checkbox"/> Week <input type="checkbox"/> Month	
Other sources of income: (describe, amount, and how often received) _____ _____					

**SECTION 5: CHILD(REN)'S INFORMATION**

Complete for the child(ren) you are requesting services for.

Are you applying for services for an unborn child?  No  Yes If yes, date baby due to be born: \_\_\_\_\_  
 If No, please provide information for each child in the section below.

<b>Child's Name</b> (Last, First, Middle, Suffix – Sr., Jr., etc.) _____				Child's Nickname _____	
Social Security Number _____		Age _____	<input type="checkbox"/> Male <input type="checkbox"/> Female		Tribal Affiliation/Enrollment # _____
Date of Birth _____	Birth City _____	Birth State _____	Birth County _____	Birth Country _____	Is the name of the Father on Child's Birth Certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Were parents married when this child was born? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, did father sign voluntary acknowledgement form? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If yes, State: _____ Agency: _____		
Where does the child live most of the time? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both Equally (Joint Custody) <input type="checkbox"/> Not yet decided by the court		Do you have custody of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, who has custody: _____		Date Custody Obtained: _____ County and State of Order: _____	
Is there an existing support order for this child? <input type="checkbox"/> Yes <input type="checkbox"/> No		County and State where Order was entered: _____		Date of Order: _____ Case Number: _____	
Who are child support payments made to? <input type="checkbox"/> State <input type="checkbox"/> Tribe <input type="checkbox"/> Custodial Party			Is this child covered by health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is child still in school? <input type="checkbox"/> Yes <input type="checkbox"/> No			Anticipated Graduation Date: _____		
School Name _____		Address _____		City _____	State _____
Does this child have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____			Does child receive Social Security Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check one: <input type="checkbox"/> SSI <input type="checkbox"/> SSDI Amount: \$ _____ / per month		

**SECTION 5: CHILD(REN)'S INFORMATION (cont.)**

<b>Child's Name</b> (Last, First, Middle, Suffix – Sr., Jr., etc.)				Child's Nickname			
Social Security Number		Age		<input type="checkbox"/> Male <input type="checkbox"/> Female		Tribal Affiliation/Enrollment #	
Date of Birth	Birth City		Birth State	Birth County	Birth Country	Is the name of the Father on Child's Birth Certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Were parents married when this child was born? <input type="checkbox"/> Yes <input type="checkbox"/> No		If No, did father sign voluntary acknowledgement form? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If yes, State: _____ Agency: _____			
Where does the child live most of the time? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both Equally (Joint Custody) <input type="checkbox"/> Not yet decided by the court		Do you have custody of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, who has custody: _____		Date Custody Obtained: _____ County and State of Order: _____			
Is there an existing support order for this child? <input type="checkbox"/> Yes <input type="checkbox"/> No		County and State where Order was entered: _____			Date of Order: _____ Case Number: _____		
Who are child support payments made to? <input type="checkbox"/> State <input type="checkbox"/> Tribe <input type="checkbox"/> Custodial Party				Is this child covered by health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is child still in school? <input type="checkbox"/> Yes <input type="checkbox"/> No				Anticipated Graduation Date: _____			
School Name		Address		City		State	Zip
Does this child have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____				Does child receive Social Security Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check one: <input type="checkbox"/> SSI <input type="checkbox"/> SSDI Amount: \$ _____ / per month			

<b>Child's Name</b> (Last, First, Middle, Suffix – Sr., Jr., etc.)				Child's Nickname			
Social Security Number		Age		<input type="checkbox"/> Male <input type="checkbox"/> Female		Tribal Affiliation/Enrollment #	
Date of Birth	Birth City		Birth State	Birth County	Birth Country	Is the name of the Father on Child's Birth Certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Were parents married when this child was born? <input type="checkbox"/> Yes <input type="checkbox"/> No		If No, did father sign voluntary acknowledgement form? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If yes, State: _____ Agency: _____			
Where does the child live most of the time? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both Equally (Joint Custody) <input type="checkbox"/> Not yet decided by the court		Do you have custody of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, who has custody: _____		Date Custody Obtained: _____ County and State of Order: _____			
Is there an existing support order for this child? <input type="checkbox"/> Yes <input type="checkbox"/> No		County and State where Order was entered: _____			Date of Order: _____ Case Number: _____		
Who are child support payments made to? <input type="checkbox"/> State <input type="checkbox"/> Tribe <input type="checkbox"/> Custodial Party				Is this child covered by health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is child still in school? <input type="checkbox"/> Yes <input type="checkbox"/> No				Anticipated Graduation Date: _____			
School Name		Address		City		State	Zip
Does this child have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____				Does child receive Social Security Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check one: <input type="checkbox"/> SSI <input type="checkbox"/> SSDI Amount: \$ _____ / per mont			

**SECTION 5: CHILD(REN)'S INFORMATION (cont.)**

<b>Child's Name</b> (Last, First, Middle, Suffix – Sr., Jr., etc.)				Child's Nickname			
Social Security Number		Age		<input type="checkbox"/> Male <input type="checkbox"/> Female		Tribal Affiliation/Enrollment #	
Date of Birth	Birth City		Birth State	Birth County	Birth Country	Is the name of the Father on Child's Birth Certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Were parents married when this child was born? <input type="checkbox"/> Yes <input type="checkbox"/> No		If No, did father sign voluntary acknowledgement form? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If yes, State: _____ Agency: _____			
Where does the child live most of the time? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both Equally (Joint Custody) <input type="checkbox"/> Not yet decided by the court		Do you have custody of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, who has custody: _____		Date Custody Obtained: _____ County and State of Order: _____			
Is there an existing support order for this child? <input type="checkbox"/> Yes <input type="checkbox"/> No		County and State where Order was entered: _____		Date of Order: _____ Case Number: _____			
Who are child support payments made to? <input type="checkbox"/> State <input type="checkbox"/> Tribe <input type="checkbox"/> Custodial Party				Is this child covered by health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is child still in school? <input type="checkbox"/> Yes <input type="checkbox"/> No				Anticipated Graduation Date: _____			
School Name		Address		City		State	Zip
Does this child have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____				Does child receive Social Security Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check one: <input type="checkbox"/> SSI <input type="checkbox"/> SSDI Amount: \$ _____ / per month			

<b>Child's Name</b> (Last, First, Middle, Suffix – Sr., Jr., etc.)				Child's Nickname			
Social Security Number		Age		<input type="checkbox"/> Male <input type="checkbox"/> Female		Tribal Affiliation/Enrollment #	
Date of Birth	Birth City		Birth State	Birth County	Birth Country	Is the name of the Father on Child's Birth Certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Were parents married when this child was born? <input type="checkbox"/> Yes <input type="checkbox"/> No		If No, did father sign voluntary acknowledgement form? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If yes, State: _____ Agency: _____			
Where does the child live most of the time? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both Equally (Joint Custody) <input type="checkbox"/> Not yet decided by the court		Do you have custody of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, who has custody: _____		Date Custody Obtained: _____ County and State of Order: _____			
Is there an existing support order for this child? <input type="checkbox"/> Yes <input type="checkbox"/> No		County and State where Order was entered: _____		Date of Order: _____ Case Number: _____			
Who are child support payments made to? <input type="checkbox"/> State <input type="checkbox"/> Tribe <input type="checkbox"/> Custodial Party				Is this child covered by health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is child still in school? <input type="checkbox"/> Yes <input type="checkbox"/> No				Anticipated Graduation Date: _____			
School Name		Address		City		State	Zip
Does this child have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____				Does child receive Social Security Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check one: <input type="checkbox"/> SSI <input type="checkbox"/> SSDI Amount: \$ _____ / per month			

**If you need additional space for more children, please request a supplemental form from your caseworker.**



**SECTION 6: HEALTH/MEDICAL INSURANCE INFORMATION**

Who is the PRIMARY policy holder for the child(ren)'s health insurance? \_\_\_\_\_  
Name Relationship to child(ren)

Name, Address and Phone Number of MEDICAL Insurance company: _____ _____ _____	Policy Number: _____ Group Number: _____	Effective Date: _____
Name, Address and Phone Number of DENTAL Insurance company: _____ _____ _____	Policy Number: _____ Group Number: _____	Effective Date: _____
Name, Address and Phone Number of OPTICAL Insurance company: _____ _____ _____	Policy Number: _____ Group Number: _____	Effective Date: _____

What dependent insurance coverage is available to you at no cost?  Medical  Dental  Optical

What dependent insurance coverage is available to you by payment of a premium? (specify cost per pay period)

Medical \$ \_\_\_\_\_ per \_\_\_\_\_  Dental \$ \_\_\_\_\_ per \_\_\_\_\_  Optical \$ \_\_\_\_\_ per \_\_\_\_\_

List all the individuals currently covered by your insurance and check which type of insurance is available to each:

Name	Birth Date	Relationship	Medical	Dental	Optical
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION 7: ADDITIONAL INFORMATION**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SECTION 8: INSTRUCTIONS FOR DOCUMENTATION**

**IMPORTANT!**

Please provide a copy of the following documents when you submit this application:

- All orders currently in place that affect each child listed such as:
  - Divorce Order
  - Custody Order
  - Child Support Order
  - Other
  
- Your driver's license or other government issued ID;
  
- Your tribal enrollment card;
  
- Your social security card;
  
- Your four (4) most recent paycheck stubs (or a statement from your employer(s) of wages and deductions and year-to-date earnings);
  - Your last tax return/
  - If self-employed you must provide a copy of your three (3) most recent business tax returns and/or corporation returns.
  
- Child(ren)'s social security card(s);
  
- Child(ren)'s birth certificate(s);
  
- Child(ren)'s tribal enrollment card(s) (if enrolled).

I understand that by submitting this application to the LCO Child Support Program (LCO CSP) I am requesting child support services under Title IV-D of the Social Security Act. I further understand that some enforcement services, such as tax offset, may be provided through a referral to the State of Wisconsin or other state IV-D agency.

**I declare that the information I provided in this application is true and accurate to the best of my knowledge and belief.**

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

The Lac Courte Oreilles Tribe is an equal opportunity employer and service provider.

The LCO Child Support Program Attorney does not represent either party but rather represents the Lac Courte Oreilles Child Support Program's interest in establishing and enforcing a support order.

Information provided on this form (including attachments) will be maintained for the purpose of administration of the LCO Child Support Program.

**Completed *Application for Services* can be hand-delivered or mailed to:**

**LCO Child Support Program  
13394W Trepania Road  
Hayward, WI 54843**