



# LAC COURTE OREILLES CHILD SUPPORT SERVICES

## Application for Services

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13526 W Trepania Rd. – Suite 202

Hayward, WI 54843

Phone: 715-318-5916\* Fax: 715-318-6080

- Please fill out this application as completely as possible. If you have questions about this application or need assistance in completing it, please contact LCO Child Support Services.
- 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.

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

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

- |  |  |
|--|--|
| <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 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 LCO Child Support.**

**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 [Who the children live with or has court ordered placement of the child(ren)]**

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: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> 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>		
<p><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, LCO Child Support Services will not proceed with your application. LCO Child Support cannot provide services to disestablish paternity. If you were not married, leave blank.</b></p>		
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.

<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: _____					

- Do you have concerns about meeting in person with the other parent?**  Yes  No
- Would you feel safe appearing in court if the other parent was present?**  Yes  No
- Do you have concerns about the other parent knowing your contact information?**  Yes  No

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 (continued)**

<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.

<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		

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

<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			

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

**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"/>

**SECTION 7: ADDITIONAL INFORMATION**

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**SECTION 8: INSTRUCTIONS FOR DOCUMENTATION**

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 or any other Orders related to the child(ren)
- 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);
- Child(ren)’s social security card(s);
- Child(ren)’s birth certificate(s);
- Child(ren)’s tribal enrollment card(s) (if enrolled).

**SECTION 9: STATEMENT OF UNDERSTANDING:**

I understand that by submitting this application to Lac Courte Oreilles Child Support Services, 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 understand that information I may provide will be kept from the general public but may be used as needed to collect support or locate the parent.

I understand that LCO Child Support Services is an equal opportunity service provider and that if I need assistance in completing this application, accommodations can be made to assist me upon my request.

I understand that the LCO Child Support Services Attorney does not represent either party but rather represents LCO Child Support Services interest in establishing and enforcing a support order.

I understand that information provided on this form (including attachments) will be maintained for the purpose of administration of LCO Child Support Services

I understand all questions asked on this Application for Services.

I understand I have the right to have my case marked with Privacy Protection when I complete a request for it be done.

I understand that if I do not respond to requests for information, appointment scheduling or the like from LCO Child Support within thirty (30) days from the date of this application, my case will be closed following the lapse of thirty (30) days and I will need to submit a new application should I wish to apply for services again in the future.

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

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

\_\_\_\_\_  
Date