SETS – CHILD SUPPORT INFORMATION FORM

NON-RESIDENTIAL PARENT INFORMATION

Name: ____ Case No.: ____________________________

Street Address: ____

City: ____ State: ___________________ Zip: ______________

Home Telephone: (________)_____________________ Work Telephone: (________)_____________________

Social Security No.: ____________________________ DOB: ___________________ Race: _____________

WITHHOLDING INFORMATION

Employer Name: ____ Employment Begin Date: ________________

Worksite Street Address: ____

City: ____ State: ___________________ Zip: ______________

Payroll Address: ____

City: ____ State: ___________________ Zip: ______________

Payroll Contact: ______________________________ Payroll Telephone: (________)_____________________

(If Withholding from a Financial Institution)

Financial Institution Street Address: ____

City: ____ State: ___________________ Zip: ______________

Bank Acct #: ____ Acct Type: _________________________

Financial Institution Telephone: (________)_____________________

RESIDENTIAL PARENT INFORMATION

Name: ____ Case No.: ____________________________

Street Address: ____

City: ____ State: ___________________ Zip: ______________

Home Telephone: (________)_____________________ Work Telephone: (________)_____________________

Social Security No.: ____________________________ DOB: ___________________ Race: _____________

Employer Name: ____ Employment Begin Date: ________________

Street Address: ____

City: ____ State: ___________________ Zip: ______________

SUPPORT ORDER

Child Support: $_________________________ per month, including processing charge

Spousal Support: $_________________________ per month, including processing charge

MEDICAL INSURANCE INFORMATION (Primary)

Name of Insured: ____

Insurance Company: ____

Street Address: ____

City: ______________________________________ State: __________________ Zip: _____________

Policy No.: _________________________________ Group No.: _________________________________

Plan Type: __________________________________ Begin Date: ________________________________

Individuals Covered: ____

MEDICAL INSURANCE INFORMATION (Secondary)

Name of Insured: ____

Insurance Company: ____

Street Address: ____

City: ______________________________________ State: __________________ Zip: _____________

Policy No.: _________________________________ Group No.: _________________________________

Plan Type: __________________________________ Begin Date: ________________________________

Individuals Covered: ____

CHILDREN FOR WHOM SUPPORT IS BEING COLLECTED

Name	*Gender*	*Race*	*DOB*	*SSN*

Submitting Attorney: ________________________________ Telephone: (________)____________________