

**STATE OF ALASKA
CHILD SUPPORT ENFORCEMENT DIVISION
550 W. 7TH AVENUE
ANCHORAGE, AK 99501-6699**

For
office use only Requested Date: _____ Mailed Date: _____

APPLICATION FOR SERVICES (NON-CUSTODIAN)

COMPLETE FRONT AND BACK OF THIS APPLICATION, SIGN AND DATE AND RETURN TO THE ABOVE ADDRESS. FILL OUT A SEPARATE APPLICATION FOR EACH PARENT/CUSTODIAN

PROVIDE COPIES OF EACH CHILD'S BIRTH CERTIFICATE



I voluntarily apply for the services of the Child Support Enforcement Division (CSED) as indicated below:

- Establishment of paternity and child support order for the child(ren) listed below.
- Support order establishment for the child(ren) listed below (paternity is already established)
- Enforcement of existing support order for the child(ren) listed below. **(PLEASE ATTACH COPY)**

I understand that I will be required to provide information necessary to establish and enforce child support.

PLEASE PRINT

YOUR NAME _____ SSN _____

NAME THAT APPEARS ON COURT ORDER (If different): _____

MAILING ADDRESS _____
City State Zip

EMPLOYER _____

EMPLOYER ADDRESS _____
City State Zip

TELEPHONE NUMBER (WORK) _____ (HOURS) _____ (HOME) _____

YOUR DATE OF BIRTH: _____ PLACE OF BIRTH: _____

YOUR PHYSICAL DESCRIPTION _____
Height Weight Hair Eyes Race

I would like to have my address protected because of domestic violence concerns. Yes No

I am the Mother Father of the following child(ren):

Full Name	Sex	Date & Place of Birth	SSN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

YOU MUST COMPLETE THE BACK OF THIS FORM

NAME OF OTHER PARENT _____

SSN _____ Male Female _____

DESCRIPTION: _____

Height Weight Hair Color Eye Color Race

YOUR MARITAL RELATIONSHIP TO OTHER PARENT: Never Married Married

Divorced - Date: _____ County/State _____ (ATTACH COPY)

NAME OF CHILD'S CUSTODIAN (if different) _____

DESCRIPTION: _____

Height Weight Hair Color Eye Color Race

SSN: _____ Male Female

CUSTODIAN/OTHER PARENT INFORMATION

TELEPHONE NUMBER (WORK) _____ (HOURS) _____ (HOME) _____

MAILING ADDRESS _____

City State Zip

RESIDENCE ADDRESS _____

City State Zip

EMPLOYER _____

Address

The children are eligible for Indian Health Service, Military or other medical coverage including insurance.
Type of coverage _____

Important Information - Please read before signing.

If you do not have a support order, CSED will set an order for you. Support charges will start with the month we receive this application, unless the children received public assistance earlier. When there is an order, either party may ask CSED to review the amount, whether it was issued by a court or by a child support agency. The review can result in either a higher or lower child support amount.

Once CSED receives this application, all support payments must be made through our office. If you make a payment before your case is set up, send CSED a copy of the canceled check or other proof of payment.

Effective October 1, 1985, Alaska Statutes require that parents provide medical support for their minor child(ren), if health insurance is available to the parent at a reasonable cost, i.e. through their employer, union, or other group health insurance program. The child support amount is adjusted to allow credit for the cost of medical insurance.

CSED will send the custodian an Application for Services and an Affidavit of Support Received. Should the custodian report past due child support and/or spousal support, this amount will become due and payable immediately unless proof is provided the debt is not owed.

I consent to CSED's enforcement of medical support for my child(ren).

Application made on this _____ day of _____, 20__

Applicant's signature: X _____

SIGNATURE IS REQUIRED FOR CSED TO PROCESS THIS APPLICATION