THIS FORM MUST BE COMPLETED AND SIGNED BEFORE YOUR ORDER CAN BE HEARD IN COURT OR FILED WITH THE SUPERIOR COURT CLERK'S OFFICE.

MERCED COUNTY DEPARTMENT OF CHILD SUPPORT SERVICES

NON-CUSTODIAL PARENT

Full Name: Last First Middle			Date of Birth: Month Day Year	Sex:
Last Known Address: Number & Street City State Zip			Phone: Home Message/Cell	
Description: Hair Eyes Height Weight		Race: ☐ White ☐ Black ☐ Native American ☐ Hispanic ☐ Asian ☐ Other		
Present or Last Known Employer: Name of Company Address City & State Phone				
Social Security Number:	Drivers License #:	Name & Address of Friend or Relative:		

CUSTODIAL PARENT

Full Name: Last First Middle			Date of Birth: Month Day Year	Sex:
Last Known Address: Number & Street City State Zip			Phone: Home Message/Cell	
Social Security Number:	Marriage Date:	Dissolution Date & County	Welfare #: (If Aided)	

CHILDREN

Name of Child(ren)	Date of Birth	Social Security #	State of Conception	Birth Place

THIS FORM CONSTITUTES AN APPLICATION FOR SERVICES.

I UNDERSTAND THAT THE DEPARTMENT OF CHILD SUPPORT SERVICES WILL ASSIST ME IN MY EFFORTS TO ENFORCE AND/OR MAINTAIN CHILD AND/OR MEDICAL SUPPORT FOR THE ABOVE CHILD(REN).

SIGNATURE OF: ☐ CUSTODIAL PARENT ☐ NON-CUSTODIAL PARENT (Check One) DATE