

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: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> 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