DHS-1201, IV-D CHILD SUPPORT SERVICES APPLICATION/REFERRAL

Michigan Department of Health and Human Services
Office of Child Support (OCS)
(Revised 6-22)

FOR OFFICE USE ONLY

Date Requested		Date Provided	Date Filed
Program	☐ 748 Provided	IV-D Case Number	MDHHS Case Number
County	District	Unit	Worker

Check your relationship to the child(ren) for whom you are applying for child support services:

☐ Custodial Parent – Complete all sections of the form, enter information about you in Section A.

☐ Non-Custodial Parent or Alleged Father – Complete all sections of the form except Section F, enter information about you in Section B.

☐ Other Caretaker, Specify

Complete all sections of the form, enter information about you in Section A. Complete information about each parent who is not in the home in Section B.

(Complete a separate application for each parent who is not in the home.)

SECTION A – INFORMATION ABOUT THE CUSTODIAL PARENT/CARETAKER OF THE CHILD

1. Name (First, Middle, Last, Suffix)		Maiden Name (if applicable)		
2. Date of Birth		3. Social Security Number		
4. Home Address (PO Box No., No. and Street)		City	State	Zip Code
County				
5. Home Phone Number	6. Work Phone Number	7. Cell Phone Number		
8. Email Address				

9. Race (Select one)

☐ Black/African American
☐ East/Southeast Asian (Chinese, Japanese, Korean)
☐ Indigenous (Native People, Native Alaskan)
☐ Middle Eastern, North African, Arab (Iranian, Syrian, West Asian)
☐ Native Hawaiian, Pacific Islander
☐ White (German, Irish, English)
☐ South Asian (East Indian, Pakistani, Bangladeshi)
☐ Multi-Racial
☐ Other
☐ Prefer not to answer/unknown

10. Ethnicity (Select one)
☐ Hispanic, Latino, Spanish origin
☐ Not of Hispanic, Latino, Spanish origin
☐ Prefer not to answer/unknown

SECTION B – INFORMATION ABOUT THE PARENT WHO IS NOT IN THE HOME

11. Parent's Name (First, Middle, Last, Suffix)	Maiden Name (if applicable)		
12. Social Security Number	13. Date of Birth	14. Age	15. Sex ☐ Male ☐ Female
16. Home Address (PO Box No., No. and Street) ☐ Current ☐ Last Known	City	State	Zip Code
17. Home Phone Number	18. Cell Phone Number		
19. Weight	20. Height	21. Hair Color	22. Eye Color
23. Email Address	24. Birthplace (City, State)		
25. Driver's License Number	26. Vehicle Year, Make, Model	27. License Plate Number	

28. Race (Select one)
☐ Black/African American
☐ East/Southeast Asian (Chinese, Japanese, Korean)
☐ Indigenous (Native People, Native Alaskan)
☐ Middle Eastern, North African, Arab (Iranian, Syrian, West Asian)
☐ Native Hawaiian, Pacific Islander
☐ White (German, Irish, English)
☐ South Asian (East Indian, Pakistani, Bangladeshi)
☐ Multi-Racial
☐ Other

29. Ethnicity (Select one)
☐ Hispanic, Latino, Spanish origin
☐ Not of Hispanic, Latino, Spanish origin

30. Identifying Marks (Scars, Tattoos, etc.)

31. Tribe Name	32. Is there a tribal support order? ☐ Yes ☐ No		
33. First Employer Name	☐ Current ☐ Last Known		
34. Employer Address (PO Box No., No. and Street)	City	State	Zip Code
35. Phone Number			
36. Second Employer Name	☐ Current ☐ Last Known		

37. Employer Address (PO Box No., No. and Street) City State Zip Code

38. Phone Number

SECTION C – MARITAL STATUS INFORMATION

39a. Has the mother ever married?
☐ No ☐ Yes (If yes, answer b, c, d)

b. Name of Spouse

c. Date Married

d. Place (City, County, State)

40a. Is the mother
☐ Separated ☐ Legally Separated (Answer b, c)

b. Date

c. Court Order Exist?
☐ No ☐ Yes (If yes, answer d, e)

d. Court Order Number

e. Where (City, County, State)

41a. Is the mother
☐ Divorced ☐ Divorce filed (Answer b, c)

b. Date

c. Court Order Exist?
☐ No ☐ Yes (If yes, answer d, e)

d. Court Order Number

e. Where (City, County, State)

Attach a copy of all court orders pertaining to the family members listed on this application, including Personal Protection Orders and guardianship papers.

SECTION D – INFORMATION ABOUT CHILD(REN)

Child One (Include separate pages if more than three children)

42a. Child's Full Name (First, Middle, Last, Suffix)

b. Date of Birth

c. Social Security Number

d. Sex
☐ Male ☐ Female

e. City, County and State of Birth

f. Who paid for the birth of child?
☐ Medicaid ☐ Private Insurance ☐ Mother ☐ Father ☐ Other

g. When and where did the mother become pregnant?

Date City County State

h. Has the father completed a document admitting he is the father of the child, such as an Affidavit of Parentage or is there a court order establishing paternity? ☐ Yes ☐ No

If yes, provide the following information about that document:

Date City County State

Child's Health Care Coverage Information (attach copy of card(s), front and back)

43a. Policy Holder's Name

b. Health Care Company Name (Non-Medicaid)

c. Coverage Type
☐ PPO ☐ PPOM ☐ Traditional

d. Policy or Group Number

Child Two

44a. Child's Full Name (First, Middle, Last, Suffix)

b. Date of Birth

c. Social Security Number

d. Sex
☐ Male ☐ Female

e. City, County and State of Birth

f. Who paid for the birth of child?
☐ Medicaid ☐ Private Insurance ☐ Mother ☐ Father ☐ Other

g. When and where did the mother become pregnant?

Date City County State

h. Has the father completed a document admitting he is the father of the child, such as an Affidavit of Parentage or is there a court order establishing paternity? ☐ Yes ☐ No

If yes, provide the following information about that document:

Date City County State

Child's Health Care Coverage Information (attach copy of card(s), front and back)

45a. Policy Holder's Name

b. Health Care Company Name (Non-Medicaid)

c. Coverage Type
☐ PPO ☐ PPOM ☐ Traditional

d. Policy or Group Number

Child Three

46a. Child's Full Name (First, Middle, Last, Suffix)

b. Date of Birth

c. Social Security Number

d. Sex
☐ Male ☐ Female

e. City, County and State of Birth

f. Who paid for the birth of child?
☐ Medicaid ☐ Private Insurance ☐ Mother ☐ Father ☐ Other

g. When and where did the mother become pregnant?

Date City County State

h. Has the father completed a document admitting he is the father of the child, such as an Affidavit of Parentage or is there a court order establishing paternity? ☐ Yes ☐ No

If yes, provide the following information about that document:

Date City County State

Child's Health Care Coverage Information (attach copy of card(s), front and back)

47a. Policy Holder's Name

b. Health Care Company Name (Non-Medicaid)

c. Coverage Type
☐ PPO ☐ PPOM ☐ Traditional

d. Policy or Group Number

SECTION E – GENERAL INFORMATION

48. I believe that disclosure of my address or other identifying information may result in physical or emotional harm to me or the child.

☐ Yes ☐ No

49. I have received or I am currently receiving benefits from the Family Independence Program (FIP) or I have received past benefits from Aid to Dependent Children (ADC).

☐ Yes ☐ No

If yes, when? Where?

50. I have received or I am currently receiving Medicaid (MA).

☐ Yes ☐ No

If yes, when? Where?

51. I am currently receiving Food Assistance Program (FAP). ☐ Yes ☐ No

I am currently receiving Child Development and Care (CDC). ☐ Yes ☐ No

SECTION F – ACKNOWLEDGEMENT FOR CUSTODIAL PARENTS AND CARETAKERS

The Michigan Office of Child Support (OCS) processes child support payments through the Michigan State Disbursement Unit (MiSDU), which is part of the Michigan Department of Health and Human Services (MDHHS). The MiSDU receipts and distributes payments by direct deposit to a bank account, to a debit card, or by paper check.

If I am sent money in error or overpaid, the MiSDU will take all the necessary steps to correct errors in the processing of my child support payments. By checking the “yes” box below, I give OCS permission to withhold an incremental amount specified below from future child support payments owed to me. To revoke my consent, I must notify the Friend of the Court office. Failure to check “yes” has no effect on my eligibility for IV-D Child Support services through OCS.

☐ Yes (check one) ☐ 10% ☐ 25% or ☐ 50%

Failure to choose a percentage will result in a default amount of 25%.

☐ No, contact me before you attempt to recover an amount from my support payments

SECTION G – ACKNOWLEDGEMENT FOR ALL APPLICANTS

I request child support services available under Title IV-D of the Social Security Act.

☐ All Services
☐ Locate Only (for custodial parents and caretakers only)
☐ Medical Support Only (for Medicaid cases only)

I understand that disclosure of my Social Security number is mandated by the Social Security Act, 42 USC 666(a)(13), in order that Michigan’s child support program may provide services related to the establishment of paternity and the establishment, modification and enforcement of child support obligations. I understand that I must cooperate in taking support action to ensure that my child support case remains open. I declare that the information provided above is true and correct to the best of my knowledge and agree to report changes in my circumstances that may affect support action in my case.

I certify that I have received a copy of DHS Publication 748, “Understanding Child Support, A Handbook for Parents.”

Applicant’s Signature (Signature is Required) ______________________ Date ____________

Applicant’s Printed Name ______________________

Return completed application to:

Michigan Department of Health and Human Services
Office of Child Support
PO Box 30744
Lansing, MI 48909

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person’s eligibility.

This institution is an equal opportunity provider.

AUTHORITIES

45 CFR 302.33 Completion: **Application is voluntary for non-assistance applicants.**

R 400.3009 MAC and R 400.5008 MAC Failure to complete may result in loss of benefits from Child Development and Care (CDC) and the Food Assistance Program (FAP). Current FAP and CDC recipients are not required to sign the form.

42 USC 654(29) Failure to provide information may result in loss of Family Independence Program (FIP) benefits for all family members and loss of Medicaid (MA) for all adult members.