Department of Human Resources
311 W. Saratoga St.
Baltimore, MD. 21201-3521

FIA ACTION TRANSMITTAL

Issuance Date: IMMEDIATELY	Effective Date: October 1, 1996
	Control Number: FIA/OPR 97-29

TO: DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES
DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT
FAMILY INVESTMENT SUPERVISORS/ELIGIBILITY STAFF

FROM: KEVIN MAHON, EXECUTIVE DIRECTOR, FIA

RE: PURCHASE OF CHILD CARE AND FAMILY INVESTMENT FORMS CONSOLIDATION

PROGRAMS AFFECTED: TEMPORARY CASH ASSISTANCE AND PURCHASE OF CARE

ORIGINATING OFFICE: OPA/ DIVISION OF PROGRAM POLICY AND REGULATION

BACKGROUND:

The responsibility of determining eligibility for the Purchase of Care Program has been transferred to the Family Investment Administration. It became apparent that there was a need to merge the forms used by the FIA workers to enable them to accomplish the additional tasks. Attached are draft forms modifications designed by the POC/FIA Forms Consolidation Workgroup.

ACTION REQUIRED:

The Purchase of Care application will be used as an extra page of the Combined Application (CAF) in all non-CARES jurisdictions other than Baltimore City. Additionally the first three pages of the CAF have been modified to include the POC program. The POC application will be used as an addendum page to the Assistance Request Form (ARF) in CARES jurisdictions. Baltimore City has developed its own version of the POC/CAF modifications to fit their particular Purchase of Care process. Modifications have been made to the 903 Assignment of Support Rights to include the Purchase of Care Program. The revised Child Support form can be used statewide.

ACTION DUE DATE: Local departments may implement the use of the consolidated forms as soon as they are printed and supplies are received.

ACTION REQUIRED OF: All Local Departments of Social Services

`FECTIVE DATE: October 1, 1996

For questions call Patricia Jeffers at 767-7143 or the DHR Help Desk at (410) 767-7002 or 1-800-347-1350.

PGJ/pgj
Attachments

cc: DHR Executive Staff
FIA Management Staff
CCA Management Staff
CSEA Management Staff

DO NOT WRITE HERE, FOR DEPARTMENT USE ONLY

Local Department | Baltimore City District | Case Number | Authorizing Worker

Case Name Last | First | MI.

Social Security No. | Race

Date Signed Application Received in Local Department

MUST BE DATE STAMPED

Category Code P / M / F

☐ Application — Specify Month

☐ Redetermination (AFDC) — Specify Month

☐ Recertification (MA,FS) — Specify Month

** NOTE:

IF YOU ARE REQUESTING HELP WITH DAY CARE ONLY YOU DO NOT NEED TO FILL OUT THE ENTIRE SIXTEEN PAGES OF THE APPLICATION. TO REQUEST ONLY DAY CARE SERVICES, COMPLETE PAGES CA-15 AND CA-16 OF THIS APPLICATION.

MARYLAND DEPARTMENT OF HUMAN RESOURCES INCOME MAINTENANCE ADMINISTRATION COMBINED APPLICATION

William Donald Schaefer
Governor

Carolyn W. Colvin
Secretary

INTENT TO FILE

Appointment Date: ________ Time: ________ LDSS Representative: ________ Date: ________

STEP 1: To begin to apply and establish your application date, you can complete this first page, tear it off and give it to us today. We are required to verify information you provide and to take action on your application within 30 days from the date you give us this completed first page. Benefits must be provided from the date you gave us this first page. The sooner you give us this first page and any required verification, the quicker you will know whether you will receive benefits. The case worker will tell you what information needs to be verified and the items to bring for your interview. You must provide the rest of the application before an eligibility decision can be made (usually within 30 days of the application date.) If you qualify to get food stamps right away, we are required to take action on your application within 5 days from the date you gave us this completed first page.

Your Name: Last Name | First | MI | Maiden/Other | Telephone number where you can be reached

Mailing Address | City | State | Zip Code

Social Security Number | Date of Birth | Race | Sex

Sign here | Today's date

ARE YOU A BOARDER? ☐ Yes ☐ No IS ANYONE IN YOUR HOUSEHOLD ON STRIKE? ☐ Yes ☐ No

WHAT TYPE(S) OF HELP ARE YOU APPLYING FOR? ☐ Public Assistance ☐ Medical Assistance ☐ Food Stamps ☐ Day Care (POC)

DO YOU HAVE CHILDREN UNDER AGE 18 LIVING WITH YOU? ☐ Yes ☐ No

COMPLETE OTHER SIDE

BALTIMORE, MARYLAND 21201
41701

STATE OF MARYLAND DEPARTMENT OF HUMAN RESOURCES

INCOME MAINTENANCE ADMINISTRATION Application For: Public Assistance • Medical Assistance • Food Stamps

MANDATORY DOCUMENTATION

Submission of a Social Security Number (SSN) is mandatory for you and all members of your household. SSN, as well as other information provided, will also be used in computer matching and program review or audits to make sure your household is eligible for Federal assistance programs, Federally assisted State programs and State only programs, such as school lunch, General Public Assistance and Medicaid. This may involve our contacting your employer, bank or other party. Fraudulent participation in the Food Stamp, Public Assistance and Medical Assistance programs may result in criminal or civil action or administrative claims.

For each person who is not a U.S. citizen you will need to show the Social Services Office either documentation from the Immigration and Naturalization Service (INS) or other documents the State agency determines are proof of your immigration status. Alien status is subject to verification with INS which may require submission of certain information from this application form to INS. Information received from INS may affect your household's eligibility and level of benefits. Each household member must certify that he or she is a U.S. citizen or is living in the U.S. in lawful immigration status.

Applicant – TO BEGIN TO APPLY FOR ASSISTANCE, COMPLETE THE ENTIRE APPLICATION, ANSWERING ALL QUESTIONS TO THE BEST OF YOUR ABILITY. THE APPLICATION WILL BE REVIEWED DURING YOUR INTERVIEW. IF YOU NEED ADDITIONAL HELP, THE AGENCY WILL HELP YOU.

A.

1. WHAT TYPE(S) OF HELP ARE YOU APPLYING FOR? ☐ Public Assistance ☐ Medical Assistance ☐ Food Stamps ☐ Day Care (POC)
2. WHY ARE YOU APPLYING? ☐ Illness or disability ☐ Pregnancy ☐ Age ☐ Unemployment ☐ Broken Marriage ☐ Other
3. DO YOU HAVE ANY OF THESE PROBLEMS? ☐ Fuel or power cut-off ☐ Eviction ☐ No food ☐ No place to stay ☐ Medical problems ☐ Medical bills in the last 3 months. ☐ Not Applicable
4. DO YOU NEED HELP WITH CHILD CARE WHILE YOU ARE AWAY FROM HOME? ☐ Yes ☐ No ☐ Not Applicable
5. IS THERE A MINOR LIVING WITH YOU WHO IS A PARENT OR AN EXPECTANT PARENT? ☐ Yes ☐ No
6. DOES ANYONE IN YOUR HOUSEHOLD NEED HELP BECAUSE OF PROBLEMS WITH DRUGS OR DRINKING? ☐ Yes ☐ No

Your Name Last First MI Maiden/Other Marital Status Telephone number where you can be reached

Your Address (where you live) Street City State Zip Code For how long?

Your mailing address (if different) City State Zip Code

Your Former Address (If at present address less than 1 year.)

Your Spouse's Las[illegible]e, If Living With You First N[illegible] M.I. Maiden/Other Name

Representative Payee [illegible]

CA 2

* (SEE PAGE #3 OF CAF) **Household members older than 13 years of Age**

Name — Last	First	Social Security No.	Date of Birth	Race	Sex	Relationship to you	Name of school or employer

* (SEE PAGE #6 OF CAF) **Income Information**

Complete those that apply for household members:

GROSS SALARY	$ per	$ per	$ per
AFDC	$ per	$ per	$ per
CHILD SUPPORT	$ per	$ per	$ per
OTHER:	$ per	$ per	$ per

Attach proof of all income for applicant, spouse, other parent in home, parents of teen parent, adult and spouse with physical custody of teen parent.

* (SEE PAGE #4 OF CAF) **Child Support Information** **(BE SURE TO CHECK 903)

Are you getting child support for all children in your household who are eligible for child support? ☐ Yes ☐ No

Have you applied for child support for all children in your household eligible to receive child support? ☐ Yes ☐ No

Do you claim good cause for not pursuing child support for any child in your household eligible for child support? ☐ Yes ☐ No
If you claim good cause, you are required to give proof of your claim. The POC worker will send you information and a form to help you with your claim.

Your application gives us information about whether you are eligible for benefits and services. Public money pays for the benefits. You must give true information. Information you give may be checked with public and private agencies and businesses. There are penalties for giving false information. Maryland law states that it is a misdemeanor to get fraudulently, or try to get, public aid. This means deliberately saying something false or pretending to be someone else. It also includes not reporting changes in household or income. Punishment for this is repayment, a fine of up to $1,000, and a possible prison sentence for up to three years.

Parent Signature	Date
Worker Signature	Date
Supervisor Signature	Date

Child Care Plan (AGENCY USE ONLY)

1. ☐ ELIGIBLE ☐ INELIGIBLE ☐ ELIGIBLE, PLACED ON WAITING LIST NUMBER IN ELIGIBILITY UNIT: ______	2. CHILD SUPPORT: __ Yes __ No __ Referral __ Non-Cooperation __ Good Cause Claim 3. DATE SERVICE TO BEGIN: ______	4. GROSS ANNUAL HOUSEHOLD INCOME:
PRIORITY CODE: ESFC REFERRAL: ☐ Yes ☐ No	6. AMF/CIS INQUIRY DATE: AMF/CIS CASE#:	7. DATE ENTERED ON CCAMIS: CCAMIS CASE#:

Department of Human Resources/Child Care Administration
Purchase of Child Day Care Program

APPLICATION/RECONSIDERATION FOR CHILD CARE

If you have requested other types of assistance in addition to Day Care service this will be the last page you need to complete. If you need Day Care only, complete pages 15 & 16.	Applicant Name:	Social Security #:	
	Address:	Telephone:	
		Date of Birth:	Race:
		Marital Status:	

Spouse/Other Parent Name (In Household):	Date of Birth:
Social Security #:	Race:

Do you now receive AFDC? ☐ *Yes,* When did you start getting AFDC? ______________

☐ *Not any more,* When did you stop getting AFDC? ______________

☐ *Never*

Are you eligible for Transitional Child Care benefits? ☐ Yes ☐ No

Are you in Project Independence (PI)? ☐ Yes ☐ No ☐ Exempt

If no, do you have a complete Employment Development Plan? ☐ Yes ☐ No

Are you a relative caretaker (not the mother or father)? ☐ Yes ☐ No

If yes, how are you related to the child(ren)? ______________

Do you receive AFDC for the child(ren)? ☐ Yes ☐ No

Activity for which you are requesting daycare (work, training program, high school/GED, college)	**Activity of Spouse/Other Parent** (work, training program, high school/GED, college)
Name of school or employer: ______________	Name of school or employer: ______________
Address of school or employer: ______________	Address of school or employer: ______________
Phone number: ______________	Phone number: ______________
Days and hours of your activity: ______________	Days and hours of your activity: ______________
Start and end dates of activity: ______________	Start and end dates of activity: ______________

Child Information

Name Last	First	Social Security No.	Date of Birth	Race	Sex	Days, Hours & Type of Care, if needed (Family, Center, Certified, Informal)

DHR/CCA 354 (AA) (Revised 9/95) Previous editions are obsolete.

C. List any household member who is pregnant: ______ NAME ______ DUE DATE ______ NAME ______ DUE DATE

D. List any household member who is disabled: ______ NAME ______ TYPE OF DISABILITY ______ NAME ______ TYPE OF DISABILITY

E. What type of assistance do you or any household member receive now?

Under what name:	Type of Assistance:
1.	1.
2.	2.
3.	3.

What type of assistance have you or any household member received in the past?

Under what name:	Type of Assistance:
1.	1.
2.	2.
3.	3.

F. What type of assistance do you need now? (check all that you need)

_____ Cash Assistance _____ Day Care Services

_____ Medical Assistance - Do you have any unpaid medical bills from the past 3 months? ____-YES ____ NO

_____ Food Stamps

G. Do you have any of these problems?

_____ Utility shut off

_____ No heat

_____ Eviction or foreclosure

_____ No food

_____ No place to stay

_____ Other - please specify ______

These are equal opportunity programs. If you believe you have been discriminated against because of race, color, age, sex, national origin, political beliefs, religion, or physical or mental disability, write to the DHR Equal Opportunity Office, 311 W. Saratoga Street, Baltimore, MD 21201, or call 1-800-332-6347.
If you believe you have been discriminated against for Food Stamps, write immediately to the Secretary of Agriculture, Washington, DC 20250.

You have the right to file an application for Food Stamps immediately by filling out your name and address and signing the front of this Request for Assistance. Benefits will be provided from the date we receive this form. You may get Food Stamps right away if you meet one of the following conditions:

- Your household's monthly rent or mortgage and utilities are more than your household's income and resources.
- Your household's gross monthly income is less than $150, and your resources, such as checking or savings accounts, are $100 or less.
- Your household has no place to live (homeless).
- our household is a migrant or seasonal farmworker household.

If you qualify to get Food Stamps right away, we will take action on your application within

DEPARTMENT OF HUMAN RESO[illegible]ES - REQUEST FOR ASSISTANCE

To request assistance, complete this section and sign your name: ______________ HOME TELEPHONE NUMBER ______________ OTHER NO. WHERE YOU CAN BE REACHED

Name: ______________________________
LAST FIRST MIDDLE INITIAL

Address: ______________________________
NUMBER AND STREET

____
CITY STATE ZIPCODE

Mailing Address: ______________________________
NUMBER AND STREET OR P.O. BOX

____
CITY STATE ZIPCODE

Signature: ______________________ Date: __________

****

Please fill out A - G if requested by the receptionist. Complete for yourself and all persons who live with you. List your own name on line 1.

A. Last Name, First, Middle, Maiden	Relationship to you	Social Security Number	Date of Birth	Sex M/F	Race	Applying for this person?	Client ID# (Office Use Only)
1.	self						
2.							
3.							
4.							
5.							
6.							

B. Please list any absent parents of children and past or present spouses not living with you.

Absent Parent's Full Name	Date of Birth	Social Security Number	Client ID# (Office Use Only)
1.			
2.			
3.			

- over -

** **OFFICE USE ONLY** **

Cat.	AU #'s	Status	Cat.	AU #'s	Status

PPI Indicator

______________ PREVIOUS ASSIGNMENT

______________ NEW ASSIGNMENT

AMF #'s	Status

Case reassign needed:

from ______________ CURRENT WORKER OF RECORD

to ______________ NEW WORKER OF RECORD

Clearer's Initials __________

Screener's Initials __________

MVA Screened

Wage Screened ______________

Household members older than 13 years of Age

Name: Last	Name: First	Social Security No.	Date of Birth	Race	Sex	Relationship to you	Name of school or employer

Income Information

Complete those that apply for household members:

GROSS SALARY	$ per	$ per	$ per
AFDC	$ per	$ per	$ per
CHILD SUPPORT	$ per	$ per	$ per
OTHER:	$ per	$ per	$ per

Attach proof of all income for applicant, spouse, other parent in home, parents of teen parent, adult and spouse with physical custody of teen parent.

Child Support Information

Are you getting child support for all children in your household who are eligible for child support? ☐ Yes ☐ No

ave you applied for child support for all children in your household eligible to receive child support? ☐ Yes ☐ No

Do you claim good cause for not pursuing child support for any child in your household eligible for child support? ☐ Yes ☐ No

If you claim good cause, you are required to give proof of your claim. The POC worker will send you information and a form to help you with your claim.

Your application gives us information about whether you are eligible for benefits and services. Public money pays for the benefits. You must give true information. Information you give may be checked with public and private agencies and businesses. There are penalties for giving false information. Maryland law states that it is a misdemeanor to get fraudulently, or try to get, public aid. This means deliberately saying something false or pretending to be someone else. It also includes not reporting changes in household or income. Punishment for this is repayment, a fine of up to $1,000, and a possible prison sentence for up to three years.

Parent Signature	Date
Worker Signature	Date
Supervisor Signature	Date

Child Care Plan (AGENCY USE ONLY)

1. ☐ ELIGIBLE
   ☐ INELIGIBLE
   ☐ ELIGIBLE, PLACED ON WAITING LIST
   NUMBER IN ELIGIBILITY UNIT: ____________

2. CHILD SUPPORT: __ Yes __ No __ Referral __ Non-Cooperation __ Good Cause Claim __

3. DATE SERVICE TO BEGIN: ____________

4. GROSS ANNUAL HOUSEHOLD INCOME:

5. PRIORITY CODE:
   FC REFERRAL: ☐ Yes ☐ No

6. AMF/CIS INQUIRY DATE:
   AMF/CIS CASE#:

7. DATE ENTERED ON CCAMIS:
   CCAMIS CASE#:

Department of Human Resources/Child Care Administration
Purchase of Child Day Care Program

APPLICATION/RECONSIDERATION FOR CHILD CARE

PURCHASE OF CHILD CARE ASSISTANCE REQUEST FORM ADDENDUM	Applicant Name:	Social Security #:	
	Address:	Telephone:	
		Date of Birth:	Race:
		Marital Status:	

Spouse/Other Parent Name (In Household):	Date of Birth:
Social Security #:	Race:

Do you now receive AFDC? ☐ *Yes,* When did you start getting AFDC? ________
☐ *Not any more,* When did you stop getting AFDC? ________
☐ *Never*

Are you eligible for Transitional Child Care benefits? ☐ Yes ☐ No

Are you in Project Independence (PI)? ☐ Yes ☐ No ☐ Exempt

If no, do you have a complete Employment Development Plan? ☐ Yes ☐ No

Are you a relative caretaker (not the mother or father)? ☐ Yes ☐ No

If yes, how are you related to the child(ren)? ________

Do you receive AFDC for the child(ren)? ☐ Yes ☐ No

Activity for which you are requesting daycare
(work, training program, high school/GED, college)

Name of school or employer: ________

Address of school or employer: ________

Phone number: ________

Days and hours of your activity: ________

Start and end dates of activity: ________

Activity of Spouse/Other Parent
(work, training program, high school/GED, college)

Name of school or employer: ________

Address of school or employer: ________

Phone number: ________

Days and hours of your activity: ________

Start and end dates of activity: ________

Child Information

Name Last / First	Social Security No.	Date of Birth	Race	Sex	Days, Hours & Type of Care, if needed (Family, Center, Certified, Informal)

DO NOT WRITE HERE, FOR DEPARTMENT USE ONLY

Local Department [ ] Baltimore City District [ ] Case Number [ ] Authorizing Worker [ ]

Case Name Last [ ] — First [ ] — MI. [ ]

Social Security No. [ ]-[ ]-[ ] Race [ ]

Category Code P / M / F

☐ Application — Specify Month

☐ Redetermination (AFDC) — Specify Month

☐ Recertification (MA,FS) — Specify Month

Date Signed Application Received in Local Department

MUST BE DATE STAMPED

MARYLAND DEPARTMENT OF HUMAN RESOURCES
INCOME MAINTENANCE ADMINISTRATION COMBINED APPLICATION

William Donald Schaefer
Governor

Project Independence

Carolyn W. Colvin
Secretary

INTENT TO FILE

Appointment Date: ______ Time: ______ LDSS Representative: ______ Date: ______

STEP 1: To begin to apply and establish your application date, you can complete this first page, tear it off and give it to us today. We are required to verify information you provide and to take action on your application within 30 days from the date you give us this completed first page. Benefits must be provided from the date you gave us this first page. The sooner you give us this first page and any required verification, the quicker you will know whether you will receive benefits. The case worker will tell you what information needs to be verified and the items to bring for your interview. You must provide the rest of the application before an eligibility decision can be made (usually within 30 days of the application date.) If you qualify to get food stamps right away, we are required to take action on your application within 5 days from the date you gave us this completed first page.

Your Name Last Name ______ First ______ MI ______ Maiden/Other ______ Telephone number where you can be reached ______

Mailing Address ______ City ______ State ______ Zip Code ______

Social Security Number ______ Date of Birth ______ Race ______ Sex ______

Sign here ______ Today's date ______

ARE YOU A BOARDER? ☐ Yes ☐ No IS ANYONE IN YOUR HOUSEHOLD ON STRIKE? ☐ Yes ☐ No

WHAT TYPE(S) OF HELP ARE YOU APPLYING FOR? ☐ Public Assistance ☐ Medical Assistance ☐ Food Stamps ☐ Day Care (POC)

DO YOU HAVE CHILDREN UNDER AGE 18 LIVING WITH YOU? ☐ Yes ☐ No

CA 1b

CASE

CASE NAME	R	S	SSN#	DOB	LOCAL DEPARTMENT	DISTRICT OFFICE

CATEGORY CASE NUMBER	AFDC ☐ NPA/MA ☐ ☐ NPA/POC	WORKER	NEW/REOPEN/EFF	CARETAKER CHANGE EFF

ABSENT PARENT DATA

NAME OF ABSENT PARENT	SOCIAL SECURITY NO.	TELEPHONE NO.

DATE OF BIRTH	AGE	SEX	RACE	BIRTH PLACE - CITY - STATE	DATE OF DEATH

LAST KNOWN ADDRESS STREET - CITY - STATE	DATE

LAST KNOWN EMPLOYER'S NAME AND ADDRESS	DATE

MARITAL STATUS OF CHILD(REN)'S PARENTS ☐ UNKNOWN ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ NEVER MARRIED TO EACH OTHER

DATE MARRIED

DATE AND PLACE DIVORCED OR SEPARATED

DOES ABSENT PARENT CARRY MEDICAL INSURANCE FOR CHILD(REN) ☐ YES ☐ NO ☐ UNKNOWN

PARENT'S CURRENT OR PRIOR MILITARY SERVICE DATES ______ TO ______

WHAT BRANCH? ☐ ARMY ☐ NAVY ☐ COAST GUARD ☐ MARINES ☐ AIR FORCE ☐ NATIONAL GUARD

IS PARENT CURRENTLY PAYING MILITARY ALLOTMENT? ☐ YES ☐ NO

CHILDREN DATA

NAME OF CHILD	SSN #	DOB	R	S	PATERNITY ESTABLISHED N/Y	PATERNITY ESTABLISHED WHAT COURT	COURT ORDER SUPPORT N/Y	COURT ORDER SUPPORT WHAT COURT

SUPPORT

DOES PARENT PAY SUPPORT? ☐ YES ☐ NO ☐ SOMETIMES

TO WHOM DOES PARENT PAY SUPPORT? ☐ TO ME ☐ TO CHILD SUPPORT AGENCY ADDRESS ______

DATE SUPPORT LAST PAID

AMOUNT

ASSIGNMENT

TO RECEIVE AFDC: I assign to the State of Maryland all rights, title, and interest in support that I may have for myself or for any person receiving AFDC. This includes any overdue support that has not been collected.
I agree to have the child support agency collect any support owed to me and to keep up to the amount of AFDC paid to me.
I agree to send to the State of Maryland any support I receive. If I do not turn over this support, I will have to repay this amount to the State of Maryland.
I may also be prosecuted for fraud.
WHEN I AM ELIGIBLE FOR MEDICAL ASSISTANCE (or POC): I assign all rights, title, and interest in medical support and health insurance payments I may have for myself or any person receiving medical assistance. This includes overdue medical support and health insurance payments that have not been collected.
I agree to have the child support agency collect medical support payments owed to me and to keep up to the amount of medical assistance payments that have been made for me.
I agree to turn over to the State of Maryland any medical support or health insurance payments I receive.
IN ORDER TO CONTINUE TO RECEIVE AFDC, ~~OR~~ MEDICAL ASSISTANCE (OR POC): I will cooperate with the child support agency. If I fail to cooperate with the child support agency, I may lose some of my benefits and my case may be closed.
I HAVE READ THESE STATEMENTS OR SOMEONE HAS READ THEM TO ME. I UNDERSTAND WHAT THEY MEAN BY SIGNING MY NAME. I AGREE TO FOLLOW WHAT THEY SAY.

SIGNATURE

DATE	SIGNATURE OF APPLICANT / RECIPIENT / Payee	Complete only in cases with representative payee. SSN #	DOB	RACE	SEX

RELATIONSHIP TO CHILD(REN)	TELEPHONE NO.	APPLICANT / RECIPIENT'S ADDRESS

[SIG]NATURE OF NATURAL PARENT IN THE HOME [OTH]ER THAN APPLICANT / PAYEE	WITNESS (IF SIGNATURE IS BY "X")

ACTION

PRIORITY CASE ☐
☐ CHILD SUPPORT RECEIVED ☐ ICM
☐ PATERNAL CARETAKER RELATIVE

CHILD SUPPORT AGENCY USE ONLY