



Mille Lacs Band –Child Support Enforcement Program
 43408 Oodena Dr.
 Onamia, MN 56359
 Phone: 320-532-7755
 Fax: 320-532-7456

APPLICATION FOR SERVICES

- Please fill out this application as completely as possible. If you have questions about this application or need assistance in completing it, please contact the MLB Child Support Enforcement Program (MLB CSEP).
- There is no application charge for initial services.
- If you are unsure of information or do not know some of the information you can leave that portion blank.
- The more information you can provide the better job your child support worker can do on your case.
- PLEASE PRINT.

SECTION 1: APPLICANT INFORMATION

Applicant's Full Name: _____

Your Relationship to Child(ren): Mother Father Grandparent Guardian Other

If you are not the parent, give parent's names: Mother: _____ Father: _____

If the children have different mothers or fathers, use a separate application for each absent parent.

Do you have a disability? YES NO

If yes, describe: _____

Does your child have a disability? YES NO

If yes, describe: _____

SERVICES REQUESTED: (Please check all that apply)

Federal regulations require the MLB-TCSE to provide all services appropriate for your case based on your circumstances.

- | | |
|--|--|
| <input type="checkbox"/> Establish Paternity | <input type="checkbox"/> Review Support Order (Modification Request) |
| <input type="checkbox"/> Establish Child Support Order | <input type="checkbox"/> Establish Medical Support Order |
| <input type="checkbox"/> Enforce (Collect) Child Support | <input type="checkbox"/> Locate Absent Parent |

Please attach copies of any and all court orders, judgments, decrees or stipulations involving child support or child custody. Whenever there are changes in the information in the future, please send copies to the MLB-CSEP.

For office use only:

Date of Request: ____/____/____ Fees Due: \$ _____ Fees Waived: YES NO

Case Type: IV-D Non-IV-D FIP/TANF Food Stamps Medicaid Locate Only Paternity Only

Inter-Jurisdictional Referral

SECTION 2: CUSTODIAL PARTY (CP) INFORMATION

Custodial Party's Name (Last, First, Middle, Suffix – Sr., Jr., etc.)				Maiden Name or Alias	
Social Security Number (SSN)	Date of Birth (DOB)	Age	Sex	Tribal Affiliation / Enrollment Number	
Birth City		Birth County		Birth State	Birth Country
Home Phone		Work Phone		Cell Phone	
Residence Address					
City				State	Zip
Mailing Address (If different from Residence)					
City				State	Zip
Member of Military? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, <input type="checkbox"/> Active <input type="checkbox"/> Retired		Branch:	
Date(s) of Service: From _____ To _____			Do you receive Veteran's Benefits? <input type="checkbox"/> YES <input type="checkbox"/> NO		

If Applicant is Child(ren)'s parent, please check current marital status:
 Married Separated Divorced Widowed Never married

Current relationship to absent parent:

<input type="checkbox"/> Married	Date	State	County	City
<input type="checkbox"/> Separated	Date	State	County	City
<input type="checkbox"/> Divorced	Date	State	County	City
<input type="checkbox"/> Annulled	Date	State	County	City

***** IMPORTANT *****

If a child was conceived or born during a marriage, the law presumes that the husband is the legal father.

If you believe that someone other than the husband may be the father, provide information about him here. The information in the remainder of this form should be about the husband and wife in

Name	Date of Birth	Social Security Number
Street Address	City	State Zip

SECTION 2: CUSTODIAL PARTY INFORMATION (cont.)

Has the custodial party ever received any of the following:			
Child Support Services [] YES [] NO	State/Tribe received from:		Dates received:
T.A.N.F. /F.I.P. [] YES [] NO	State/Tribe received from:		Dates received:
Food Stamps [] YES [] NO	State(s) received from:		Dates received:
Medicaid [] YES [] NO	State(s) received from:		Dates received:
Child Care [] YES [] NO	State(s) received from:		Dates received:
Custodial Party's Employment and Income			
Employer Name:			
Address:			State Zip
Phone Number:		Fax Number:	
Your Start Date:	Job Title:	Hours worked per week:	Hourly Pay Rate: \$
		How often are you paid? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly	
Do you have an Occupational/Professional License? [] YES [] NO		If yes, type of license:	

SECTION 3: CHILD CARE INFORMATION

Do you have child care Expenses? [] YES [] NO	Names of children receiving child care: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
Number of Hours per week for child care:	Cost per Hour: \$
Name/Address/Phone Number of Child Care Provider:	Check the reason for child care: <input type="checkbox"/> Work related <input type="checkbox"/> Looking for Employment <input type="checkbox"/> Enrolled in educational program to improve employment opportunities

SECTION 4: NON-CUSTODIAL PARTY (NCP) INFORMATION

This is the parent who is absent from the home and/or the alleged father. **Use separate form for each absent parent.**

Non-Custodial Party's Name (Last, First, Middle, Suffix – Sr., Jr., etc.)				Maiden Name or Alias	
Social Security Number (SSN)	Date of Birth (DOB)	Age	Sex	Tribal Affiliation / Enrollment Number	
Birth City		Birth County		Birth State	Birth Country
Home Phone		Work Phone		Cell Phone	
Residence Address [] Current [] Last Known					
City				State	Zip
Mailing Address (If different from Residence) [] Current [] Last Known					
City				State	Zip
Member of Military? [] YES [] NO		If yes, [] Active [] Retired		Branch:	
Date(s) of Service: From _____ To _____		Do they receive Veteran's Benefits? [] YES [] NO [] Unknown			
Distinguishing Marks (Tattoos, Scars, birth marks, etc.)		Height	Weight	Eyes	Hair
Current Marital Status: [] Married [] Separated [] Divorced [] Widowed [] Never Married [] Unknown					
Mother's Maiden Name			Father's Name		
Has Non-Custodial Party Ever Been Convicted of a Crime? [] YES [] NO		Date and Place of Arrest:		Probation/Parole Officer:	
Date(s) Non-Custodial Party lived in Custodial Party's household: From _____ to _____ City/ State _____					

Please provide any additional information you believe would be helpful to locate this person. Include names and addresses of friends or relatives who might know how to locate this person. Please include a picture of the person if possible.

Non-Custodial Party's Employment and Income

Employer Name:					
Address:				State	Zip
Phone Number:			Fax Number:		
Start Date:	Job Title:	Hours worked per week:	Hourly pay Rate: \$	How often paid? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly	
Does Non-Custodial Party have an Occupational/Professional License? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown			If yes, type of license:		
Health Insurance Available. Please check all that apply. <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Optical		List all persons covered by the Health Insurance:	Premium amount paid: \$ _____ Family Plan \$ _____ Single Plan	Per: <input type="checkbox"/> Pay Period <input type="checkbox"/> Week <input type="checkbox"/> Month	

SECTION 5: CHILD(REN)'S INFORMATION

Complete for the child(ren) you are requesting services for.

Are you applying for services for an unborn child? NO YES if yes, expected due date: _____

If No, please provide information for each child in the section below.

1. Child's Name (Last, First, Middle, Suffix – Sr., Jr., etc.)			Child's Nickname		
Social Security Number	Age	<input type="checkbox"/> Female <input type="checkbox"/> Male	Tribal Affiliation		
Date of Birth	Place of Conception (City, State)	Place of Birth (City)	Birth County	Birth State	Birth Country
Were parents married when this child was born? <input type="checkbox"/> YES <input type="checkbox"/> NO		If NO, did father sign voluntarily acknowledgement form? <input type="checkbox"/> YES <input type="checkbox"/> NO		If YES, State: _____	
Does this child live with you? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, where does child live?		Do you have custody of this child? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, who has custody?		Agency: _____	
Date Custody Obtained: _____		County and State of Order: _____			
Is there an existing support order for this child? <input type="checkbox"/> YES <input type="checkbox"/> NO	County and State where Order was entered:	Date of Order: Case Number:	Who are child support payments made to? <input type="checkbox"/> State <input type="checkbox"/> Tribe <input type="checkbox"/> CP	Is this child covered by health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Is child still in school? <input type="checkbox"/> YES <input type="checkbox"/> NO			Anticipated Graduation Date:		
School Name	Address	City	State	Zip	
Does this child have a disability? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, describe disability: _____			If yes, check one: <input type="checkbox"/> SSI <input type="checkbox"/> SSDI Amount: \$ _____ / per month		
Does Child Receive Social Security Benefits? <input type="checkbox"/> NO <input type="checkbox"/> YES					

SECTION 5: CHILD(REN)'S INFORMATION (cont.)

2. Child's Name (Last, First, Middle, Suffix – Sr., Jr., etc.)				Child's Nickname			
Social Security Number		Age	<input type="checkbox"/> Female <input type="checkbox"/> Male	Tribal Affiliation			
Date of Birth	Place of Conception (City, State)		Place of Birth (City)		Birth County	Birth State	Birth Country
Were parents married when this child was born? <input type="checkbox"/> YES <input type="checkbox"/> NO		If NO, did father sign voluntarily acknowledgement form? <input type="checkbox"/> YES <input type="checkbox"/> NO		If YES, State: _____ Agency: _____			
Does this child live with you? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, where does child live?		Do you have custody of this child? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, who has custody?		Date Custody Obtained: _____ County and State of Order: _____			
Is there an existing support order for this child? <input type="checkbox"/> YES <input type="checkbox"/> NO	County and State where Order was entered:	Date of Order: Case Number:	Who are child support payments made to? <input type="checkbox"/> State <input type="checkbox"/> Tribe <input type="checkbox"/> CP		Is this child covered by health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Is child still in school? <input type="checkbox"/> YES <input type="checkbox"/> NO			Anticipated Graduation Date:				
School Name		Address		City	State	Zip	
Does this child have a disability? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, describe disability: _____			If yes, check one: <input type="checkbox"/> SSI <input type="checkbox"/> SSDI Amount: \$ _____ / per month				
Does Child Receive Social Security Benefits? <input type="checkbox"/> NO <input type="checkbox"/> YES							
3. Child's Name (Last, First, Middle, Suffix – Sr., Jr., etc.)							
3. Child's Name (Last, First, Middle, Suffix – Sr., Jr., etc.)				Child's Nickname			
Social Security Number		Age	<input type="checkbox"/> Female <input type="checkbox"/> Male	Tribal Affiliation			
Date of Birth	Place of Conception (City, State)		Place of Birth (City)		Birth County	Birth State	Birth Country
Were parents married when this child was born? <input type="checkbox"/> YES <input type="checkbox"/> NO		If NO, did father sign voluntarily acknowledgement form? <input type="checkbox"/> YES <input type="checkbox"/> NO		If YES, State: _____ Agency: _____			
Does this child live with you? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, where does child live?		Do you have custody of this child? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, who has custody?		Date Custody Obtained: _____ County and State of Order: _____			
Is there an existing support order for this child? <input type="checkbox"/> YES <input type="checkbox"/> NO	County and State where Order was entered:	Date of Order: Case Number:	Who are child support payments made to? <input type="checkbox"/> State <input type="checkbox"/> Tribe <input type="checkbox"/> CP		Is this child covered by health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Is child still in school? <input type="checkbox"/> YES <input type="checkbox"/> NO			Anticipated Graduation Date:				
School Name		Address		City	State	Zip	
Does this child have a disability? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, describe disability: _____			If yes, check one: <input type="checkbox"/> SSI <input type="checkbox"/> SSDI Amount: \$ _____ / per month				
Does Child Receive Social Security Benefits? <input type="checkbox"/> NO <input type="checkbox"/> YES							

SECTION 5: CHILD(REN)'S INFORMATION (cont.)

4. Child's Name (Last, First, Middle, Suffix – Sr., Jr., etc.)					Child's Nickname		
Social Security Number		Age	<input type="checkbox"/> Female <input type="checkbox"/> Male	Tribal Affiliation			
Date of Birth	Place of Conception (City, State)		Place of Birth (City)		Birth County	Birth State	Birth Country
Were parents married when this child was born? <input type="checkbox"/> YES <input type="checkbox"/> NO		If NO, did father sign voluntarily acknowledgement form? <input type="checkbox"/> YES <input type="checkbox"/> NO		If YES, State: _____ Agency: _____			
Does this child live with you? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, where does child live?		Do you have custody of this child? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, who has custody?		Date Custody Obtained: _____ County and State of Order: _____			
Is there an existing support order for this child? <input type="checkbox"/> YES <input type="checkbox"/> NO	County and State where Order was entered:		Date of Order: Case Number:	Who are child support payments made to? <input type="checkbox"/> State <input type="checkbox"/> Tribe <input type="checkbox"/> CP		Is this child covered by health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Is child still in school? <input type="checkbox"/> YES <input type="checkbox"/> NO				Anticipated Graduation Date:			
School Name		Address		City	State	Zip	
Does this child have a disability? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, describe disability: _____			If yes, check one: <input type="checkbox"/> SSI <input type="checkbox"/> SSDI Amount: \$ _____ / per month				
Does Child Receive Social Security Benefits? <input type="checkbox"/> NO <input type="checkbox"/> YES							
5. Child's Name (Last, First, Middle, Suffix – Sr., Jr., etc.)					Child's Nickname		
Social Security Number		Age	<input type="checkbox"/> Female <input type="checkbox"/> Male	Tribal Affiliation			
Date of Birth	Place of Conception (City, State)		Place of Birth (City)		Birth County	Birth State	Birth Country
Were parents married when this child was born? <input type="checkbox"/> YES <input type="checkbox"/> NO		If NO, did father sign voluntarily acknowledgement form? <input type="checkbox"/> YES <input type="checkbox"/> NO		If YES, State: _____ Agency: _____			
Does this child live with you? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, where does child live?		Do you have custody of this child? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, who has custody?		Date Custody Obtained: _____ County and State of Order: _____			
Is there an existing support order for this child? <input type="checkbox"/> YES <input type="checkbox"/> NO	County and State where Order was entered:		Date of Order: Case Number:	Who are child support payments made to? <input type="checkbox"/> State <input type="checkbox"/> Tribe <input type="checkbox"/> CP		Is this child covered by health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Is child still in school? <input type="checkbox"/> YES <input type="checkbox"/> NO				Anticipated Graduation Date:			
School Name		Address		City	State	Zip	
Does this child have a disability? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, describe disability: _____			If yes, check one: <input type="checkbox"/> SSI <input type="checkbox"/> SSDI Amount: \$ _____ / per month				
Does Child Receive Social Security Benefits? <input type="checkbox"/> NO <input type="checkbox"/> YES							

If you need additional space for more children, please request a supplemental form from your caseworker.

SECTION 6: HEALTH/MEDICAL INSURANCE INFORMATION

Who is the PRIMARY policy holder for the children's health insurance? _____					
Name			Relationship to Child(ren)		
Name, Address and phone number of medical insurance company:		Policy Number:	Effective Date:		
		Group Number:			
Name, Address and phone number of dental insurance company:		Policy Number:	Effective Date:		
		Group Number:			
Name, Address and phone number of optical insurance company:		Policy Number:	Effective Date:		
		Group Number:			
What dependent insurance coverage is available to you at no cost? <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Optical					
What dependent insurance coverage is available to you by payment of a premium? (specify cost per pay period)					
<input type="checkbox"/> Medical \$_____ per _____ <input type="checkbox"/> Dental \$_____ per _____ <input type="checkbox"/> Optical \$_____ per _____					
List all the individuals currently covered by your insurance and check which type of insurance is available to each:					
Name	Birth Date	Relationship	Medical	Dental	Optical

SECTION 7: ADDITIONAL INFORMATION

SECTION 8: INSTRUCTIONS FOR DOCUMENTATION

IMPORTANT!

Please provide a copy of the following documents when you submit this application:

- All orders currently in place that affect each child listed such as:
 - Divorce Order
 - Custody Order
 - Child Support Order
 - Other
- Your driver's license or other government issued ID;
- Your enrollment card;
- Your social security card;
- Your four (4) most recent paycheck stubs (or a statement from your employer(s) of wages and deductions and year-to-date earnings);
 - Your last tax return;
 - If self-employed you must provide a copy of your three (3) most recent business tax returns and/or corporation returns.
- Children's social security cards;
- Children's birth certificates;
- Children's enrollment cards.

I understand that by submitting this application to the Mille Lacs Band –Child Support Enforcement Program (MLB-CSEP) agency I am requesting child support services under Title IV-D of the Social Security Act. I further understand that some enforcement services, such as tax offset, may be provided through a referral to the State of Minnesota IV-D agency or other state IV-D agency.

I declare that the information I provided in this application is true and accurate to the best of my knowledge and belief.

Applicant Signature

Date

Mille Lacs Band of Ojibwe is an equal opportunity employer and service provider. If you have a disability and need to access this information in an alternative format, or need it translated to another language, please contact the MLB-CSEP at 320-532-7755.

The MLB-CSEP Attorney does not represent either party but rather represents the Mille Lacs Band's interest in establishing and enforcing a child support and/or paternity order.

Information provided on this form (including attachments) may be shared with others for the sole purpose of administration of the tribal child support agency and other related programs.

CASE CLOSURE REQUEST

TO: STATE OF MINNESOTA CHILD SUPPORT ENFORCEMENT AGENCY

CP: _____ SSN: _____ DOB: _____

NCP: _____ SSN: _____ DOB: _____

CHILD: _____ SSN: _____ DOB: _____

CHILD: _____ SSN: _____ DOB: _____

CHILD: _____ SSN: _____ DOB: _____

CHILD: _____ SSN: _____ DOB: _____

CHILD: _____ SSN: _____ DOB: _____

CHILD: _____ SSN: _____ DOB: _____

I, _____, hereby request that the State of Minnesota Child Support Enforcement Agency in the County of _____, close my child support enforcement case so that the Mille Lacs Band Child Support Enforcement Program (MLB-CSEP) can assume management and jurisdiction over my case.

I understand that if there are state-owed debts associated with my case, my case will remain open in the State of Minnesota however the MLB-CSEP will be the agency to enforce and collect on those debts on behalf of the State.

I understand that if I am receiving public assistance benefits through the State of Minnesota or the Mille Lacs Band that I must cooperate with MLB-CSP and assist in establishing and enforcing child support/paternity orders.

Signature

Date