



# Child Support Program

CS-ES51  
Rule 12E-1.039  
Florida Administrative Code  
Effective 09/19/17

## Application for Child Support Services

The Florida Department of Revenue Child Support Program provides full child support services.

### The Child Support Program will:

- Attempt to find the other parent(s)
- Establish paternity, if needed
- Obtain an order for child support or medical support
- Send you payments we collect
- Review changes in your and the other parent's circumstances and determine whether a change in the amount of support ordered is necessary
- Review available income information as needed
- Base the support amount on the income of both parents
- Calculate the amount of support to be paid
- Notify you if it appears you are not cooperating with us, and give you a chance to respond within 60 days before we close your case

### You must:

- Cooperate with us
- Provide us with all the requested information
- Provide copies of all requested documents we need
- Provide a copy of the health insurance card if the child(ren) is insured
- Notify us of any changes in information for you, the child(ren) or other parent(s). This includes addresses, employment, phone numbers, and where the child(ren) lives
- Keep all appointments with us
- Go to all court or administrative hearings
- Notify us when you want to close your case(s)
- You must complete a new application to reopen the case if the case has been closed

To apply for child support services for the child(ren) named below, you must accept all the following terms and conditions:

- I understand that the Florida Department of Revenue's attorneys represent the Department only and do not represent me.
- I want to apply for child support services for the child(ren) named in this application and I agree to cooperate with the Florida Department of Revenue Child Support Program.
- I am a parent or caregiver of a child(ren) included in this application for services.
- To the best of my knowledge, I have provided true and correct information in this application.

Name(s) of child(ren)

Name of other parent(s)

_____	_____
_____	_____
_____	_____
_____	_____

Print your full name

Your signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (\_\_\_\_\_)\_\_\_\_\_

Date Your daytime phone number

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You must complete all pages on both sides of this form.

FOR DOR USE ONLY:

APR  IPR  NPR

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## My Information

Your Full Name (First, Middle, Last, Suffix):		
I have a fear of physical or emotional harm from the other parent(s): <input type="checkbox"/> Yes <input type="checkbox"/> No		
You are the child(ren)'s: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Caregiver		
Child(ren) primarily lives with: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Caregiver		
Social Security Number: _____ - _____ - _____	Date of Birth: ____/____/____	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male
Mailing Address:	Driver's License No.:	Issuing State
City:	Country:	Home Phone (include area code):
State:	Zip Code:	Work Phone (include area code):
Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Other	Email Address:	
Other Names You Are Known By: _____ <input type="checkbox"/> Maiden <input type="checkbox"/> Former married <input type="checkbox"/> Nickname		
<b>Answer employment questions only if you are the mother or the father</b>		
Employer:		
Employer's Address:		
Employer's City:	Employer's State:	Employer's Zip:
<b>Answer health insurance questions only if you are the mother or the father</b>		
Health Insurance Company:	Phone Number:	
Policy Number:	Group Number:	
Is health insurance provided by your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		

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Social Security number disclosure is mandatory based on Title 42 United States Code sections 666(a)(13), 653a, and 654a(e), and on section 409.2577, Florida Statutes. We collect social security numbers for child support purposes. For more information go to [www.floridarevenue.com/pages/privacy.aspx](http://www.floridarevenue.com/pages/privacy.aspx).

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## Mother/Father Information

A separate <b>Mother/Father Information form</b> is required for the other parent(s) of each child who needs services.					
Parent's Full Name (First, Middle, Last, Suffix):				Are you seeking child support from this parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Social Security Number: _____ - _____ - _____		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male		Date of Birth: ____/____/____	
Home Phone (include area code):			Cell Phone (include area code):		
Mailing Address:					Country:
City:	State:	Zip code:	Driver's License No.:	Issuing State:	
Employer:			Employer's Address:		
Employer's City:	Employer's State:	Employer's Zip:	Is health insurance provided by this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Health Insurance Company:			Phone Number:		
Policy Number:			Group Number:		
Other Names Known By:					
Height:	Hair Color:	Eye Color:	Other Identifying Features (scars, tattoos, or birth marks):		
Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Other					
List this parent's children (or possible children) included in this application. Complete a separate Child's Information form for each child listed.					
<b>Child's Full Name (First, Middle, Last, Suffix):</b>		<b>Child's Social Security Number:</b>		<b>This Parent's Relationship to the Child (Mother or Father):</b>	
_____		_____		_____	
_____		_____		_____	
_____		_____		_____	
_____		_____		_____	
Is this parent a citizen of the US? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is this parent a member of a Tribal Association? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is this parent in jail or prison? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where? _____					
Is this parent in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what branch? _____					
Is this parent disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is this parent a member of a union? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does this parent have any special licenses, certifications, or specialized area of work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list: _____					

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## Child's Information

Child's Full Name (First, Middle, Last, Suffix): _____		
Date of Birth: _____	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security Number: _____-_____-_____
Child's Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Other		
Child's Place of Birth (City/ County /State/Country): _____		Birth Certificate Number: _____
Is a father's name on the birth certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please print father's name: _____		
Is there a support order for this child? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Person who is ordered to pay support: _____ Person receiving support: _____		
Date of order: ____/____/____ Court Case number: _____		
County/state/country where order was entered: _____		
Where is support paid? <input type="checkbox"/> Clerk of Court <input type="checkbox"/> State Disbursement Unit <input type="checkbox"/> Directly to me <input type="checkbox"/> Other state's Child Support Agency		
Is there health insurance for this child? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please print the name of the person providing health insurance: _____		
Is there a pending legal action that involves this child? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If yes, type of pending legal action: <input type="checkbox"/> Custody <input type="checkbox"/> Adoption <input type="checkbox"/> Mediation <input type="checkbox"/> Enforcement <input type="checkbox"/> Modification <input type="checkbox"/> Other: _____		
Please print the name of the person taking legal action: _____		
Your attorney's name, address and phone #: _____		
<b>IF THIS CHILD IS INCLUDED IN A SUPPORT ORDER DO NOT COMPLETE THE REMAINING QUESTIONS FOR THIS CHILD</b>		
Please list the name(s) of all possible fathers of this child: _____		
Where did the mother become pregnant? State: _____ Country: _____		
Was the mother married when she became pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, to whom? _____		
Date of marriage: ____/____/____ Married where (City/ County /State/Country): _____		
Was the mother married when this child was born? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, to whom? _____		
Date of marriage: ____/____/____ Married where (City/ County /State/Country): _____		
Was the mother divorced from the man named above? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, date of divorce: ____/____/____		
Court Case #: _____ Divorced where (City/ County /State or Country): _____		
Has this child ever lived with the other parent in Florida? <input type="checkbox"/> Yes <input type="checkbox"/> No Other parent's name: _____		
If yes, please provide the approximate dates: From ____/____/____ to ____/____/____		
City in Florida where they lived together: _____		

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**NOTE: The 4<sup>th</sup> page of this form is the CS-ES51 ACI. An additional form generates for each child in the case over the first child.**

**NOTE: The marksense fields are completed by DOR staff when the application is returned. No marksense processing is necessary at this time.**

**FOR DOR USE ONLY**

APR IPR NPR

**APR – Appropriate payment received**

**IPR – Inappropriate payment received**

**NPR – No payment received**