THIS FORM MUST BE COMPLETED AND SIGNED BEFORE YOUR ORDER CAN BE HEARD IN COURT OR FILED WITH THE SUPERIOR COURT CLERK'S OFFICE.

Reserved for Court's Case Number:

MERCED COUNTY DEPARTMENT OF CHILD SUPPORT SERVICES

NON-CUSTODIAL PARENT

Full Name: Last First Middle	Date of Birth: Month Day Year	Gender: ☐ M ☐ F ☐ Nonbinary
Last Known Address: Number & Street City State Zip	Phone: ( ) Home ( ) Message/Cell	
Description: Hair Eyes Height Weight	Preferred Language: ☐ English ☐ Spanish ☐ Other _____	
Social Security #:	Driver's License or ID #	Race: ☐ White ☐ Hispanic ☐ Black ☐ Asian ☐ Native American ☐ Other
Present or Last Known Employer: Name of Company: Address City & State Phone	Name and Address of Friend or Relative:	

CUSTODIAL PARENT / GUARDIAN

Full Name: Last First Middle	Date of Birth: Month Day Year	Gender: ☐ M ☐ F ☐ Nonbinary
Last Known Address: Number & Street City State Zip	Phone: ( ) Home ( ) Message/Cell	
Social Security #	Marriage Date: Dissolution Date & County:	Preferred Language: ☐ English ☐ Spanish ☐ Other _____
Receiving Public Assistance: ☐ NO ☐ YES Welfare #		

CHILDREN

Name of Child(ren)	Date of Birth	Social Security Number	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