

**REFERRAL TO CHILD  
SUPPORT ENFORCEMENT**

Disclosure of your Social Security Number is mandatory. The disclosure is required by 42 U.S.C. 405(c)(2)(c). It will be used by the Wyoming Child Support Enforcement Program to identify you for purposes of establishing paternity and establishing, modifying, and enforcing support obligations.

Field Office: \_\_\_\_\_ EPICS Number: \_\_\_\_\_ POSSE Number: \_\_\_\_\_

**Custodian's Name:** \_\_\_\_\_

First Middle Last

Mailing Address: \_\_\_\_\_

Residence Address: \_\_\_\_\_

Cell/Home Phone # \_\_\_\_\_ Birth Date: \_\_\_\_\_ Birthplace: \_\_\_\_\_ SSN: \_\_\_\_\_

City and State

Employment: Company Name and Address and Phone Number: \_\_\_\_\_

Are you now: Single:  Married:  Divorced:  Separated:  Never Married:

Relationship to the Child/Children listed below: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Do you have a restraining/protective order against the other parent? Yes  No  If so: City: \_\_\_\_\_ State: \_\_\_\_\_

Only list children who are applying/receiving POWER, Family Care or Foster Care:

Child's Name:	Birth Date:	Sex:	Birthplace: (City/County/State)	Social Security Number:

**Complete a report for each non-custodial parent. Complete all questions. If unknown, please check here .**

Parent's Name: \_\_\_\_\_  
First Middle Last

Relationship to above child(ren): \_\_\_\_\_ Birth Date: \_\_\_\_\_ Approximate Age: \_\_\_\_\_

Birthplace City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ SSN: \_\_\_\_\_

Alias First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Sex: M  F  Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Ethnic Heritage: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Is other parent now: Single  Married:  Divorced:  Separated:  Never Married:

Current or last known residence address: \_\_\_\_\_

Current or last known mailing address: \_\_\_\_\_

Current or last known cellular/telephone number: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Date you last had contact with other parent: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ How? \_\_\_\_\_

Name and address of current or last known employer: \_\_\_\_\_

Last employment date (month and year): \_\_\_\_\_

Military Service? Yes  No  If yes, Branch of Service: \_\_\_\_\_ Dates of Service: \_\_\_\_\_

Disabled? Yes  No  If yes, Month/Year: \_\_\_\_\_ Disability Income Source: \_\_\_\_\_

Child(ren) receive Social Security Benefits? Yes  No  SSI? Yes  No

In Jail or Prison? Yes  No  If yes, Date: \_\_\_\_\_ City and State: \_\_\_\_\_

Name, address and phone number of other parent's father: \_\_\_\_\_

Name, address and phone number of other parent's mother (include maiden name): \_\_\_\_\_

**Marital and Child Support Information:**

Were you married when child(ren) was born? Yes  No  If yes, Date, City and State of marriage: \_\_\_\_\_

Were you married when child(ren) was conceived? Yes  No  If yes, Date, City and State of Conception: \_\_\_\_\_

Were you married to anyone other than the parent when the child(ren) was born? Yes  No  (If yes, another DFS 543 must be filled out.)

Name: \_\_\_\_\_ Date of Marriage: \_\_\_\_\_ City and State of Marriage: \_\_\_\_\_

If you were not married to the other parent when child was born was paternity:

a. Established by Court Order? Yes  No  If yes, Date: \_\_\_\_\_ City/County/State: \_\_\_\_\_

b. Affidavit of Paternity signed? Yes  No  If yes, Paternity Denied:  Paternity Admitted:

c. Other parent informed of pregnancy? Yes  No

Is there a child support order or divorce decree? Yes  No  If yes, County/State: \_\_\_\_\_

Date Child Support last received: \_\_\_\_\_ Amount of Child Support last received: \_\_\_\_\_

Child Support received from other parent? Yes  No  Clerk of Court? Yes  No  County/State: \_\_\_\_\_

Does either parent carry medical insurance for the child(ren)? Yes  No  Name of child(ren): \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Have you retained an attorney? Yes  No  If yes, name of attorney: \_\_\_\_\_

Client's statement: I have read the Child Support Cooperation Notice/Good Cause Claim: (Check one of the boxes below)

- I will cooperate with the pursuit of child support.
- I do not want to co-operate with the pursuit of child support and am exercising my right to request an exemption based on good cause. (Please check the appropriate box on the back of EACH copy of this form.)

For POWER or Foster Care, the State may withhold an incremental amount, at a reasonable rate, from future child support payments to correct an overpayment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Worker's Statement: I have provided the applicant/recipient with a copy of the Child Support Cooperation Notice/Good Cause Claim. (If good cause has been requested, indicate your recommendation of approval or denial and furnish applicable comments.)

Worker's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Distribution: CSES Case File Applicant/Recipient

### Child Support Cooperation Notice/Good Cause Claim

**ASSIGNMENT OF SUPPORT:** I understand that I hereby assign any rights to support to the State of Wyoming as a condition of eligibility for POWER. I assign any rights to back support owed me prior to the time I received POWER. By signing the application for POWER, I understand any amount of support I am owed or paid while receiving POWER, or foster care, for myself or on behalf of children named on the application, must be turned into the Department of Family Services (DFS). I agree to turn in 1) payment on back support; 2) payment on current or future support; 3) all payments for child support or alimony and medical costs; and 4) payments on support assigned to the state received after I stop receiving POWER. The State of Wyoming may deduct an amount, at a reasonable rate, from future child support payments to correct an overpayment.

**MEDICAL ASSIGNMENT:** I understand I am assigning to the State of Wyoming all rights to Medical support or payments for medical expenses from any other person paid on my behalf or on behalf of any other person for whom application for POWER and/or Family Care/Kid Care A/B is made. This means: 1) if I get Family Care/Kid Care A/B and also get money for the same medical bills, I must give the money to WY Dept. of Health and 2) the state may collect from any insurance company or court settlement for our medical bills.

**COOPERATION NOTICE:** You are required by law to cooperate with DFS in collecting child support for the child(ren) for whom you want POWER. Family Care/Kid Care A/B only recipients are required to cooperate in obtaining medical support and establishing paternity. To cooperate means you must: name the absent parent of your child(ren); help to locate the parent; help to determine the legal father of a child born out of wedlock; and, if you are under age 18, cooperate in seeking support from your parents. You must also help to get support from the parent and pay the State any money you receive from the parent. You may also have to come to the public assistance or child support office and give more information or go to court to sign papers.

There are advantages in helping to determine who the legal father of your child is. In the future, you and your child may be eligible for social security or other similar government benefits. You may also get more in support payments than you would get from public assistance payments.

**GOOD CAUSE CLAIM:** However, if you believe that cooperating would not be in the best interest of your child(ren), you may ask to be excused from cooperation. This is called "Good Cause." You may claim good cause for refusing to cooperate in pursuing child support or in establishing paternity for a child born out of wedlock. The claim must be based on one of the factors listed below.

If you wish to claim good cause, check one or more of the following:

- Cooperation would result in serious physical harm to me reducing my ability to adequately care for my child(ren).
- Cooperation would result in serious emotional harm to me reducing my ability to adequately care for my child(ren).
- Cooperation would result in serious physical harm to my child(ren).
- Cooperation would result in serious emotional harm to my child(ren).
- The child was conceived as a result of incest or forcible rape.
- Legal action for adoption of the child(ren) is pending before a court.
- I am receiving counseling to help me decide whether to keep the child(ren) or relinquish the child(ren) for adoption.

**You must provide proof to support your claim within 20 days of the date you sign this form. If there is a good reason why you cannot get the proof within 20 days, you may request additional time. You will not receive an assistance payment until a decision has been made on your claim.**

The following are examples of acceptable kinds of evidence you can use to support your good cause claim:

- Court, medical, criminal, law enforcement, psychological, child protection or social service records. They must show that the absent parent might cause serious physical or emotional harm to the child(ren) or you.
- Medical or mental health records indicating that required cooperation would cause serious emotional harm to the child(ren) or you.
- Birth, medical or law enforcement records proving the child was conceived as a result of incest or forcible rape.
- Documents to establish that adoption proceedings are now before a court.
- A statement from a public or private social agency showing that you are being assisted in deciding whether or not to relinquish the child(ren) for adoption.
- Sworn statements from persons within the community who know the circumstances supporting your claim.

The DFS, State Office, will evaluate the evidence and may conduct an investigation in order to decide if cooperation will be against the best interests of the child(ren) or yourself. The DFS, field office, will provide reasonable assistance to help you get the proof. No contact will be made with the absent parent during the evaluation.

If your good cause claim is approved, the State will NOT try to collect support or establish who the father is. The State may request a re-review of the decision on your claim. Additional evidence may be needed for the re-review. The review due date and information needed will appear in your approval notice.

If your good cause claim is denied, the denial notice will list your options. If you continue to be denied and do not cooperate, you will not be eligible for POWER nor Family Care medical assistance. Your child(ren) will still be eligible for Kid Care A/B if eligibility factors are met. I understand that being denied good cause may result in this case being pursued. You do have the right to request an administrative hearing on the adverse decision.