NORTH Dakota | Child Support
Be Legendary. HEALTH & HUMAN SERVICES

Child Support
PO Box 7190
Bismarck, ND 58507-7190
Telephone: (701) 328-5440 TTY: 711
Email: childsupport@nd.gov
Website: childsupportnd.gov

date

employer name
address
city, state, zip

## REQUEST FOR INFORMATION

This request is made pursuant to state law. See N.D.C.C. § 14-09-08.16 and N.D.C.C. § 50-09-08.2(5).

| | |
|---|---|
| **Re:** | name of person |
| **Social security number:** | 999-99-9999 |
| **Last known address:** | address<br>city, state, zip |
| **Case number:** | 9999999 |



1. Is the individual currently employed by you as an employee or contractor?

   ☐ Yes (Skip #2. Complete #3 through #20.)
   ☐ No (Go to #2.)

2. Was the individual employed by you during the 180 days immediately preceding the date of this request?

   ☐ Yes; date employment ended: _____/_____/_____ (complete #3 through #20)
   ☐ No (Skip #3 through #19. Complete #20.)

3. The social security number under which you report(ed) the individual's income is _____

4. The individual's address is/was: _____
   _____

   The individual's phone number is/was: _____

   The individual's email address is/was: _____

5. Individual's position/job title and brief job description: _____
   _____
   _____



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6. Date individual's employment began: ___/___/_____

7. Individual's rate of pay:

Hourly: $ _____ per hour; _____ hours per week
Monthly: $ _____ per month
Annually: $ _____ per year
Other: $ _____

Account information provided for payment purposes (i.e., direct deposit), if applicable:

Bank Name: _____
Bank Address: _____
Individual's Account Number: _____

8. Please provide the gross income, such as salary, wages, overtime wages, tips, commissions, and bonuses paid to the above-named individual in each of the 12 months preceding the month in which this request was received:

| | | | | | |
|---|---|---|---|---|---|
| mo/yr | _____ | $ _____ | mo/yr | _____ | $ _____ |
| mo/yr | _____ | $ _____ | mo/yr | _____ | $ _____ |
| mo/yr | _____ | $ _____ | mo/yr | _____ | $ _____ |
| mo/yr | _____ | $ _____ | mo/yr | _____ | $ _____ |
| mo/yr | _____ | $ _____ | mo/yr | _____ | $ _____ |
| mo/yr | _____ | $ _____ | mo/yr | _____ | $ _____ |

9. Does the gross income shown in #8 include any overtime wages?

☐ Yes
☐ No

10. If the answer to #9 is yes, please provide the number of overtime (OT) hours worked by the individual in each of the 12 months preceding the month in which this request was received:

| | | | | | |
|---|---|---|---|---|---|
| mo/yr | _____ | OT hours _____ | mo/yr | _____ | OT hours _____ |
| mo/yr | _____ | OT hours _____ | mo/yr | _____ | OT hours _____ |
| mo/yr | _____ | OT hours _____ | mo/yr | _____ | OT hours _____ |
| mo/yr | _____ | OT hours _____ | mo/yr | _____ | OT hours _____ |
| mo/yr | _____ | OT hours _____ | mo/yr | _____ | OT hours _____ |
| mo/yr | _____ | OT hours _____ | mo/yr | _____ | OT hours _____ |

11. If the answer to #9 is yes, do you expect the overtime hours to continue during the next 12 months?

☐ Yes
☐ No

12. Does the gross income shown in #8 include any bonuses?

☐ Yes
☐ No

13. If the answer to #12 is yes, please provide the amount of bonuses paid to the individual in each of the three (3) previous calendar years:

Year: _____ Amount: $ _____
Year: _____ Amount: $ _____
Year: _____ Amount: $ _____

14. If the answer to #12 is yes, do you expect to pay bonuses during the current calendar year?

☐ Yes
☐ No

15. Is the individual currently enrolled in a health insurance plan through the individual's employment? (Check all that apply.)

- ☐ Yes; enrolled in:
  - ☐ Single plan
  - ☐ Single + dependent plan
  - ☐ Family plan
- ☐ No
- ☐ No plan available
- ☐ Employee not eligible for coverage.
  Employee will become eligible for coverage on _____.
- ☐ Not applicable as individual no longer employed.

16. If the individual is enrolled in a health insurance plan, please list the names of the persons covered under the policy and the effective date of coverage:

| Name | Effective Date |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |



17. If the individual is enrolled in a health insurance plan, please provide the following information:

Name of insurance company: _____

Address of insurance company:

_____

_____

_____

Telephone number of insurance company (if multiple numbers, please provide the "member services" number) _____

Group number _____

Policy number _____

18. If a health insurance plan is available to the individual or if the individual is enrolled in a health insurance plan, please provide the following information (complete **all** options that are available):

| | | |
|---|---|---|
| Individual's cost for a single plan is | $ _____ | per month |
| Individual's cost for a single+dependent plan is | $ _____ | per month |
| Individual's cost for a family plan is | $ _____ | per month |
| Individual's cost to cover a child or children only is | $ _____ | per month |

If the individual is enrolled in a health insurance plan, is the individual's cost deducted on a pre-tax basis?

☐ Yes
☐ No

19. If the individual is no longer employed by you, please provide the following information:

Date of last payment to the individual: _____

Individual's forwarding addresses (if known):

Home: _____

_____

New employer: _____

_____

_____

Did the individual voluntarily terminate employment?

☐ Yes
☐ No

20. Name of person completing form: _____
Title: _____
Business Federal Employer Identification Number: _____
Telephone number: _____
Cellular phone number: _____
Fax number: _____
Email address: _____
Preferred method of contact (phone, fax, email, etc.,): _____
Date: _____

Please return this form to the Child Support Division within ten (10) days. You may mail it to the above address or, if you prefer, you may fax it to the above fax number. The information received from you will be used only in the administration of the child support program in implementing the program and its services. Failure to comply with this request may result in fiscal sanctions or contempt of court.

Thank you for your cooperation.

Child Support Worker Name
Title