MONTEREY COUNTY

DEPARTMENT OF CHILD SUPPORT SERVICES

752 La Guardia Street
Post Office Box 2059
Salinas, CA 93902
www.co.monterey.ca.us/mcdcss

Phone: 831/755.3200
Facsimile: 831/796.0232
TDD: 831/769.9306

Employer Name: ______________________

Employer Address: ______________________

____

Employer Telephone: ______________________

Date:______________

Case #:______________________

Your Employee: ______________________

SSN: ______________________

DOB: ______________________

MAY USE OTHER NAMES

Dear Personnel Director:

The following information is required from your office/labor organization to compute child support. Your are required to furnish this information pursuant to Family Code section 17512. Please complete this form, with your signature in the certification section, and return it to us. If you have questions, the number to call is (831) 755-3200.

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By: ______________________

ALL INFORMATION TO BE COMPLETED BY EMPLOYER

Employed: From ____________ To ____________ Full Time _____ Part Time _____ Other _____

In other, specify: __________ Hourly rate if applicable: $________ Hours worked per week: ______
Pay frequency (i.e. bi-weekly, monthly, semi-monthly, etc.) ______________________________

Occupation __________________________ Union Affiliation _______________________

Presently Employed? ____ If not presently employed, please state reason for separation:
____

New Employer? If yes, please provide: ____

Current Workers Compensation action in progress? _____ If yes, WC Claim No: ______________

Date of birth __________ Soc. Sec. No. __________ Drivers License No. __________ State _______

Employee's Address:
Worksite: ______________________
____
____
Phone: ______________________

Home: ______________________
____
____
Phone: ______________________

PLEASE INDICATE THE FOLLOWING MONTHLY DEDUCTIONS

Compulsory Union Dues* $___________ **Compulsory Retirement Deduction*** $___________
Health Insurance $___________

***Compulsory means these deductions are required as a condition of employment.**

EMPLOYEE STATUS

Married__________ **Single**__________ **No. Exemptions Claimed**__________

Child and/or Spousal support deducted from pay monthly $___________

MOST RECENT EARNINGS STATEMENT

MONTH	YEAR	GROSS PAY	MONTH	YEAR	GROSS PAY
JANUARY	___________	$___________	JULY	___________	$___________
FEB	___________	$___________	AUGUST	___________	$___________
MARCH	___________	$___________	SEPTEMBER	___________	$___________
APRIL	___________	$___________	OCTOBER	___________	$___________
MAY	___________	$___________	NOVEMBER	___________	$___________
JUNE	___________	$___________	DECEMBER	___________	$___________

HEALTH INSURANCE INFORMATION

Is health insurance coverage available to employee?___________, to his/her dependents?__________

Are his/her children currently covered?__________

What is the employee's monthly cost per child to cover children on the health plan? $__________

Employee's Policy #:___________ Policy State Date:__________ End Date:____________

If child(ren) are currently covered by this employee on a health plan, please complete the following information. This information is critical for the child(ren) to be able to utilize the health plan coverage. If additional children are covered, attach a separate sheet and list the children and policy numbers.

Name of Health Insurance Company or Union: ______________________________________
Street Address of Insurance Company: ______________________________________
(Address where claims are mailed) ______________________________________
Insurance Company Telephone #: ______________________________________
Insurance Policy effective date: ______________________________________

Child's Name: _____________ **Policy #:**__________ **Child's Name:**__________ **Policy #:**__________
Child's Name: _____________ **Policy #:**__________ **Child's Name:**__________ **Policy #:**__________

Name of Dental Insurance Company or Union: ______________________________________
Street Address of Insurance Company: ______________________________________
(Address where claims are mailed) ______________________________________
Insurance Company Telephone #: ______________________________________
Insurance Policy effective date: ______________________________________

Child's Name: _____________ **Policy #:**__________ **Child's Name:**__________ **Policy #:**__________
Child's Name: _____________ **Policy #:**__________ **Child's Name:**__________ **Policy #:**__________

Name of Vision Insurance Company or Union: ______________________________________
Street Address of Insurance Company: ______________________________________
(Address where claims are mailed) ______________________________________
Insurance Company Telephone #: ______________________________________
Insurance Policy effective date: ______________________________________

Child's Name: _____________ **Policy #:**__________ **Child's Name:**__________ **Policy #:**__________
Child's Name: _____________ **Policy #:**__________ **Child's Name:**__________ **Policy #:**__________

CERTIFICATION OF RECORD

I have personally prepared the summary of the employee's earnings and health benefits from the payroll records in my custody and control. I am personally aware such payroll records are kept in the regular course of business and that entries therein are made throughout the course of employment. I have compared the payroll records with the above statement of earnings or health benefits and know it to be accurate. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

DATED: _____________________ **SIGNATURE:** _____________________
FIRM: _____________________ **NAME:** _____________________
ADDRESS: _____________________ **TITLE:** _____________________
PHONE #: _____________________ **FAX #:** _____________________