Additional Child Information (Referral)

*To be completed when the Applicant has **more than two (2) children** with the Other Party named in this referral.*
Submit with Part A and Part B of the LDSS-5145

Name of Child # [   ]

First [_____] Middle [_____] Last [_____] Suffix [____]

SSN/ITIN [_____] **Gender** ☐ Female ☐ Male ☐ Non-Binary/Other **Date of Birth** *(Month/Day/Year)* [_____] ☐ Unborn Due Date [_____]

Name of Parent

Parent 1 First [_____] Middle [_____] Last [_____]

Parent 2 First [_____] Middle [_____] Last [_____]

Child's Birthplace

Hospital [_____] City [_____] State [____] Country [_____]

Other Party's Relationship to the Child

☐ Parent ☐ Stepparent ☐ Alleged Father

Parents' Marital Status

Were the parents listed above married at or after the time of the child's birth?

☐ Yes, to each other ☐ Yes, but not to each other ☐ No ☐ Unknown

If ***Yes, to each other***, go to the ***Order of Support Information*** questions. **Otherwise**, go to the ***Paternity Establishment*** questions.

Paternity Establishment

Was paternity established?

☐ Yes - Complete the ***Paternity Establishment*** questions.
      You **do not** need to complete the ***State of Jurisdiction*** questions.

☐ No - Go to the ***State of Jurisdiction*** questions.
☐ Unknown - Go to the ***State of Jurisdiction*** questions.

How was paternity established?

☐ Established in Court on [_____] Name of Court [_____]

☐ Acknowledgment of Paternity on [_____]

In what county, state, and country was paternity established?

County [_____] State [____] Country [_____]

Where was the child conceived? State [____] Country [_____]

State of Jurisdiction

Did the alleged father (AF) provide prenatal expenses or support for the child? ☐ Yes ☐ No ☐ Unknown

Did the AF reside with the child in New York State? ☐ Yes ☐ No ☐ Unknown

Does the child reside in New York State as the result of acts or directives of the AF? ☐ Yes ☐ No ☐ Unknown

Order of Support Information

Is there an order of support for this child? ☐ Yes ☐ No ☐ Unknown If "Yes," what is the date of the order? [_____]

Is health insurance ordered? ☐ Yes ☐ No ☐ Unknown

Obligation Amount

$ [_____] ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice per month ☐ Other [_____]

Court that Issued the Order

☐ Family ☐ Supreme ☐ Other [_____]

County [_____] State [____] Country [_____]

Health Care Coverage Information

Does the child have health care coverage? ☐ Yes ☐ No ☐ Unknown

If "Yes," identify the type of coverage: ☐ Private – Go to ***Health Insurance Benefits*** questions.
☐ Public – Go to ***Public Health Care Coverage*** questions.

Health Insurance Benefits

Who provides the child's private health care coverage?

☐ Custodial Parent ☐ Guardian ☐ Noncustodial Parent/ Alleged Father ☐ Stepparent ☐ Unknown ☐ Other

Name of Health Insurance Carrier [_____] Policy # [_____] Group # [_____]

Street [_____] Floor/Apt./Suite [_____] City [_____] State [____] ZIP [____]

Public Health Care Coverage

Indicate the type of public health care coverage:

☐ Medicaid ☐ Child Health Plus (CHPlus) CHPlus monthly contribution: $ [_____]

☐ Other [_____]