LDSS-5145A (Rev. 09/21)

Additional Child Information (Referral)

To be completed when the Applicant has ***more than two (2) children*** *with the Other Party named in this application.*

Submit with the LDSS-5145

Name of Child #

First Middle Last Suffix

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

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 Parent Intended Parent

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 ***Parentage Establishment*** questions.

Parentage Establishment

Was parentage established?

Yes - Complete the ***Parentage 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 parentage established?

Established in Court on Name of Court

Acknowledgment of Paternity/Parentage on Surrogacy/assisted reproduction agreement

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

County State Country

Where was the child conceived? State Country

State of Jurisdiction

Did the Alleged Parent/Intended Parent provide prenatal expenses or support for the child? Yes No Unknown

Did the Alleged Parent/Intended Parent 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 Alleged Parent/Intended Parent? 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 Parent/Intended Parent 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