

**PORTAGE COUNTY CHILD SUPPORT ENFORCEMENT AGENCY
SUPPORT PAYMENT REGISTRATION FORM
449 SOUTH MERIDIAN STREET, 2ND FLOOR
RAVENNA, OH 44266**

DATE: _____ CASE NO: _____

1. PAYOR INFORMATION (one making support payments)

Name:			Social Security No:		
Address:					
Number		Street		City	
				State	
				Zip	
Telephone (home):			(cell):		
Your Atty's Name:			Phone:		
Employer's Name:					
Employer's Address:					
Number		Street		City	
				State	
				Zip	
Are you currently paying another agency? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please state who:			Case No:		
Driver's License No:			Date of Birth:		

2. PAYEE INFORMATION (one receiving payments)

Name:			Social Security No:		
Address:					
Number		Street		City	
				State	
				Zip	
Telephone (home):			(cell):		
Are you on Welfare?: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Your Atty's Name:			Phone:		
Driver's License No:			Date of Birth:		

3. HEALTH INSURANCE INFORMATION

Who is ordered to provide health insurance coverage? <input type="checkbox"/> Payor? <input type="checkbox"/> Payee?	
Insurance Company Name:	
Name of Health Plan:	
Address:	
Number	
Street	
City	
State	
Zip	
Customer Service Phone Number:	
Group Number:	I.D. Number:

4. Child's Name Date of Birth Social Security No.

I/we hereby certify that the above information is correct to the best of my/our knowledge.

***You may write any additional
information on the back of this
form, if you wish.**

Payor's Signature

Payee's Signature