

**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