

# MONTEREY COUNTY



## DEPARTMENT OF CHILD SUPPORT SERVICES

752 La Guardia Street  
Post Office Box 2059  
Salinas, CA 93902  
[www.co.monterey.ca.us/mcdcscs](http://www.co.monterey.ca.us/mcdcscs)

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

Employer Name: \_\_\_\_\_

Date: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Case #: \_\_\_\_\_

Your Employee: \_\_\_\_\_

Employer Telephone: \_\_\_\_\_

SSN: \_\_\_\_\_

DOB: \_\_\_\_\_

MAY USE OTHER NAMES

Dear Personnel Director:

FOR EXPEDITED SERVICE, EMPLOYERS ONLY, MAY CALL THE DEPARTMENT OF CHILD SUPPORT SERVICES HOTLINE AT (831) 796-3658.

The following information is required from your office/labor organization to compute child support. You 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.

MONTEREY COUNTY  
DEPARTMENT OF CHILD SUPPORT SERVICES

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: \_\_\_\_\_

Home: \_\_\_\_\_

Phone: \_\_\_\_\_

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 forgoing is true and correct.

DATED:

SIGNATURE:

COMPANY:

NAME:

PHONE#

TITLE:

FAX#:

NUMBER OF ATTACHMENTS: