Request for Review and Adjustment

Online Forms Instructions

- Complete the Review and Adjustment packet which includes the following documents:
    - Request for Review and Adjustment
    - Financial Form
    - Health Insurance Verification Form (if the you are the custodial parent)
- Scan or take a photo of the completed forms and additional required documents and email to askdcse@dss.virginia.gov.
- A review and adjustment specialist will contact you to confirm receipt of your documents and gather any further needed information.

Commonwealth of Virginia
Department of Social Services
Division of Child Support Enforcement

PO Box 550
Richmond, VA 23218
http://www.dss.virginia.gov/family/dcse/
1-800-468-8894

REQUEST FOR REVIEW AND ADJUSTMENT

Name _____ Date _____

Address _____ Division Case Number _____

_____

_____

Please read this information before submitting the attached request for a review of your child support order.

If it has been 3 years since your child support order was entered, modified or reviewed, you may request a review. Complete the attached request form indicating this to be the reason for your request.

If it has been less than 3 years since your child support order was entered, modified or reviewed, there must be a special circumstance to justify the request. The special circumstances and required documents are:

- A child needs to be added to the order due to birth or change in physical custody. Provide child's name and birth date.
- A child is no longer eligible to receive current support due to a change in physical custody or emancipation (and other children are active on the order). Provide child's name and birth date.
- Health care coverage cost increases or decreases by at least 25%. Provide a statement from the insurer or employer that specifies the cost of the child(ren)'s premium to the insured. You may provide current and previous costs of the child(ren)'s premium in writing on the request, but only if you cannot obtain a statement from the insurer or employer.
- A health care coverage obligation needs to be added to the order. No documentation is necessary.
- The order does not include an unreimbursed medical/dental provision. No documentation is necessary.
- Either parent's income increases or decreases by at least 25%. Submit the last three pay stubs, an income earning statement from the employer, or any other form of income verification available to you with this request and list the reason for the change of income. If your decrease or loss of income is not voluntary, please provide verification with this request.
- Either parent is a Reservist or National Guard member whose income is changing due to recall to active duty. Provide any document that supports a return to active duty.
- The parent who owes child support is incarcerated for 180 or more consecutive days.
- Work-related child care expenses increase or decrease by at least 25%. Submit a statement from the child care provider that specifies the child care cost and the name(s) of the child(ren) in the provider's care.

The Division will conduct a review if a special circumstance applies to the other party and you cannot obtain the required documentation. However, as the requesting party, you must provide an explanation of the other party's special circumstance.

You must indicate the reason for the request. If your request is based on a change in circumstance, the change must qualify as one of the special circumstances listed above. Clearly state the special circumstance and provide the required

documentation. The Division will not accept any requests that do not indicate the reason and include the required documentation.

Once the Division receives a request, it may only be withdrawn by written request; however, if the non-requesting party objects to the withdrawal, action to complete the review will continue.

A review could result in an upward or downward modification or indicate no modification is warranted at this time.

To request a review, complete and sign the Request for Review and Adjustment below and submit this form and the required documentation to the address above.

To obtain additional case and/or payment information, visit our customer service portal at http://mychildsupport.dss.virginia.gov/.

REQUEST FOR REVIEW AND ADJUSTMENT

Division Case Number: _____

I request a review because:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Printed Name Signature

Date: _____ Address: _____

_____

_____

Cell Phone: _____

Email Address: _____

Commonwealth of Virginia
Department of Social Services
Division of Child Support Enforcement

FINANCIAL STATEMENT

DATE: Division Case Number:

The Financial Statement is used to determine the proper amount of child support for your case. It is important to return this document along with proof of income and expenses within the specified time frame in order to receive proper credit on the support obligation worksheet.

SECTION A: HOUSEHOLD/SUPPORT ORDER INFORMATION

CP/NCP FIRST NAME MIDDLE NAME LAST NAME
Social Security Number: _____ Date of Birth: _____
Mailing Address: _____
City, State, Zip: _____
Residential Address: _____
(if different) _____
Phone Home: _____ Work: _____ Cell: _____
Email address: _____
Your nearest living relative: _____ Relationship: _____
Relative's Address: _____
City, State, Zip Code: _____ Phone: _____
Names of dependents in this case:

_____ _____ _____
_____ _____ _____

Dependents living with you for whom you are the biological or adoptive parent:

Child's Name	Birth Date	Relationship

Other persons presently supported by you under any court or administrative order:

Name	Address	Birth Date	Relationship

Order Date/Type (Court or Administrative)	Payee (Person you pay)	Ordered Amount ($ amt and pay frequency)	Total Amount Paid (Over last 6 months)

To receive credit for the above payments, you must provide proof such as pay stubs, receipts from the custodial parent on the case, or other documents that verify payments.

If you pay or receive spousal support/alimony, provide the following information:

Order Date	Issuing Court	$ Amount/Frequency	Paid to/Received from

SECTION B: INCOME / EMPLOYMENT

Are you self-employed? ☐ Yes ☐ No

NOTE: If you are self-employed, you must submit your most current tax return including all Schedules, as well as a record of all self-employment tax you have paid this calendar year. Self-employed individuals may be entitled to deductions from their gross monthly income that can only be determined if you provide this information.

Employer: _____ Employment Date: _____

Employer's Address: _____

City, State, Zip Code: _____ Employer Phone: _____

Occupation: _____ Hourly Rate: _____

Pay Frequency (check one): ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly (twice/month) ☐ Monthly

Do you receive overtime pay? ☐ Yes ☐ No

Gross pay per period: _____
(amount paid before deductions including overtime/shift differential pay if applicable)

Do you have a 2nd job? ☐ Yes ☐ No If yes, provide secondary employer information:

Employer: _____ Employment Date: _____

Employer's Address: _____

City, State, Zip Code: _____ Employer Phone: _____

Occupation: _____ Hourly Rate: _____

Pay Frequency (check one): ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly (twice/month) ☐ Monthly

Do you receive overtime pay? ☐ Yes ☐ No

Gross pay per period: _____
(amount paid before deductions including overtime/shift differential pay if applicable)

Important: Attach copies of your 3 most recent pay stubs or a written statement from your employer(s) verifying your average gross monthly income.

Do you receive income from any other source? ☐ Yes ☐ No Monthly amount: _____

Income is defined as salaries, wages, commissions, royalties, bonuses, dividends, severance pay, pensions, interest, trust income, annuities, capital gains, social security benefits, workers' compensation benefits, unemployment insurance benefits, disability insurance benefits, veteran's benefits, spousal support, rental income, gifts, prizes or awards.

Current gross monthly income (total amount of income from all sources indicated above): _____

Total income over last 12 months (total amount of all W-2's): _____

Past employment and periods of unemployment: List all previous employers and periods of unemployment for the last 12 months:

Name	Address	Gross Monthly Income	Employment Dates

SECTION C: HEALTH INSURANCE

Please provide proof of insurance and insurance costs.

Is health insurance available at your place of employment? ☐ Yes ☐ No

Do you have health insurance? ☐ Yes ☐ No

Are the children on this case included in the policy? ☐ Yes ☐ No

Name and relationship of others covered in this policy:

Name	Relationship

Name of insurance company: _____ Policy number: _____

Is vision insurance available at your place of employment? ☐ Yes ☐ No

Do you have vision insurance? ☐ Yes ☐ No

Are the children on this case included in the policy? ☐ Yes ☐ No

Name and relationship of others covered in this policy:

Name	Relationship

Name of insurance company: _____ Policy number: _____

Is dental insurance available at your place of employment? ☐ Yes ☐ No

Do you dental health insurance? ☐ Yes ☐ No

Are the children on this case included in the policy? ☐ Yes ☐ No

Name and relationship of others covered in this policy:

Name	Relationship

Name of insurance company: _____ Policy number: _____

If insurance is not available through your employer, is it available through other groups or organizations or your union?

☐ Yes ☐ No If yes, what group? _____

Please provide the following information if you are providing insurance or if insurance coverage is offered through your employer or another group or organization (the costs for each option must be provided to receive credit for the cost of providing coverage):

Cost of health insurance:	Employee only	$ _____	per	_____
	Employee plus 1	$ _____	per	_____
	Employee plus family	$ _____	per	_____
Cost of vision insurance:	Employee only	$ _____	per	_____
	Employee plus 1	$ _____	per	_____
	Employee plus family	$ _____	per	_____
Cost of dental insurance:	Employee only	$ _____	per	_____
	Employee plus 1	$ _____	per	_____
	Employee plus family	$ _____	per	_____

SECTION D: DEPENDENT CARE EXPENSES

Please provide proof of dependent care expenses. A statement or multiple receipts from the child care provider must be provided in order to receive credit.

List only child care information necessary due to your employment (for children on this case only):

Child Care Provider	Phone Number	Amount paid	Frequency

Does the Department of Social Services pay any portion of your child care expenses? ☐ Yes ☐ No

If yes, amount paid: $ _____ per _____

SECTION E: PROPERTY AND RESOURCES

Do you own in whole or part any of the following?

Real Estate (Land or Buildings): ☐ Yes ☐ No

Fair Market Price	Location	Amount Owed	Mortgagee	Income Producing	Profit per Year
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

Other assets: ☐ Yes ☐ No

If yes, please explain: _____

Bank accounts: ☐ Yes ☐ No

Name of bank or credit union: _____

I hereby certify under penalty of perjury as set forth in Va. Code § 63.2-502 that I have given the statements in this document and they are true and correct. I further agree to notify the Division of Child Support Enforcement of any changes in my income or expenses.

Signature _____ Date _____

According to Va. Code § 63.2-1919, financial statements from noncustodial and custodial parents must be filed with the Department of Social Services upon request as long as a debt to the Department exists or an authorization for the Department to collect or enforce a support obligation exists. Failure to return this financial statement may adversely affect your child support obligation and shall constitute a Class 4 misdemeanor.

To obtain additional case and/or payment information, visit our customer service portal at https://mychildsupport.dss.virginia.gov/.

NOTICE: Section 7 of the Privacy Act (5 USC § 552a) and Section 466(a)(13) of the Social Security Act [42 USC§ 666(a)(13)] require all individuals subject to child support orders to provide their social security numbers. These numbers will be kept in the case records and will only be used to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF CHILD SUPPORT ENFORCEMENT

Health Insurance Verification Notice

Date: _____

Dear _____, DCSE Case# _____

This form must be returned to DCSE within 5 days. Failure to return the form along with requested documentation may result in case closure for non-cooperation, as DCSE will be unable to complete the guidelines to establish the order.

Under the Affordable Care Act (ACA), the person who claims the child as a tax deduction is responsible for providing health insurance for the child. Please check if any of the following apply to your situation:

☐ The non-custodial parent claims the child(ren) as a tax deduction.
Attach a court order which orders the non-custodial parent to claim the child(ren).

☐ The non-custodial parent currently has insurance for the child(ren).
Attach proof of insurance.

☐ The child(ren) is(are) currently covered by Medicaid.
Attach proof of insurance.

☐ The child(ren) is(are) currently covered by FAMIS.
Attach proof of insurance.

☐ The child(ren) is(are) currently covered by my insurance or my spouses insurance.
Attach proof of insurance and proof of the cost of insurance for only the child(ren).

If you did NOT select any of the above, then you must pursue insurance for the child(ren) and select an option below. You may find subsidized options available at www.healthcare.gov.

☐ I will obtain insurance, which may include Medicaid/FAMIS, for the child(ren) prior to my appointment with DCSE, my court hearing, or returning my financial statement as requested.
Provide proof of insurance and proof of the cost of insurance for only the child(ren) when you come to your appointment, your court hearing or return your financial statement as requested.

☐ Open enrollment periods at my employer and www.healthcare.gov prevent me from enrolling the child(ren) in insurance prior to my appointment with DCSE, my court hearing, or returning my financial statement as requested.
Provide proof of open enrollment periods and proof of the cost of insurance for only the child(ren) when you come to your appointment, your court hearing or return your financial statement as requested.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF CHILD SUPPORT ENFORCEMENT

Health Insurance Verification Notice

☐ The child(ren) does(do) not qualify for Medicaid/FAMIS and the cost of insurance through both my employer and www.healthcare.gov for only the child(ren) is more than 5% of the combined monthly gross income of both parents.

Provide proof of the cost of insurance through both your employer and through www.healthcare.gov.

Once you have obtained insurance, the cost of the insurance for only the child(ren) will be shared between you and the non-custodial parent based upon your shares of your combined monthly gross income.

Thank you for your cooperation.

Sincerely,

_____

Authorized Representative