CLARK COUNTY
OFFICE OF THE DISTRICT ATTORNEY
Family Support Division

STEVEN B. WOLFSON
District Attorney

1900 E. Flamingo Rd., Suite 100 • Las Vegas, NV 89119 • 702-671-9200 • Fax: 702-366-2410 • TTY and/or other relay services: 711

CHRISTOPHER LALLI *Assistant District Attorney*
ROBERT DASKAS *Assistant District Attorney*
BRIGID J. DUFFY *Assistant District Attorney - Juvenile Division*
KAREN S. CLIFFE *Assistant District Attorney - Family Support*
LISA LOGSDON *County Counsel*

Non-Custodial Parent Review & Adjustment Application

A modification of a child support order may be requested if there has been a substantial change of circumstances since the order was entered. Changed circumstance is defined by statute as an increase or decrease in gross monthly income of 20% or more. It also includes factual changes in the parties' circumstances such as emancipation of a child or the addition of a new child to the family.

If you have more than one case with this office and you apply for modification services, this office will assess all of your cases which reflect active current child support.

This office **does** modify current child support and enforce and/or add an order for health insurance coverage, when necessary. The District Attorney's Office represents the interests of the State of Nevada in enforcing health insurance and financial support of children. This office **does not** represent either party.

This office **DOES NOT** modify:
Spousal support Orders that are arrears only Unreimbursed medical expenses

This office **DOES NOT** handle custody or visitation issues. A Visitation/Access Mediation Program is available to assist with visitation for those who qualify. For more information on this program, contact them at (702) 455-4186.

The completed application & proof of current income may be sent via:
Fax# (702) 366-2329 or **E-mail**: DAFSReview@ClarkCountyDA.com

If your application is approved, our office will contact you to attempt to complete the process without a court hearing. Failure to cooperate may result in denial of your request.

THE MODIFICATION PROCESS MAY TAKE UP TO SIX MONTHS TO COMPLETE.

Non-Custodial Parent Review & Adjustment Application

Note: Submittal of this application will result in an assessment of all active current child support cases with our office. An action will be taken on any case that meets the criteria for a review & adjustment. If a court hearing is scheduled, your presence is required; failure to appear at court may result in the denial of the motion and no change to the existing order.

Your name _____ SSN _____

Address _____

Email address _____ Home/Cell phone number _____

Employer's name _____ Employer's phone number _____

Employer's address _____

My occupation / type of work: _____ Start Date _____

I have the following Professional, Occupational, Recreational Licenses: _____

Hourly wage: $ _____. Hours per week: _____. Pay cycle: ☐ weekly ☐ monthly ☐ 2-week

My total GROSS MONTHLY income is $ _____

My monthly bills are:

Rent/House Payment/Mortgage ….. $ _____ Average Monthly Utilities …... $ _____

Car Payment/Lease…… $ _____ Monthly Food Costs …… $ _____

Cable/Satellite …… $ _____ Cell Phone ……... $ _____

Health Insurance (provide proof of coverage and costs:

☐ Not available ☐ Available ☐ Medicaid ☐ Employer ☐ Union Cost per month: $ _____

Day care costs for the child/ren on this case (provide proof): $ _____ ☐ per week ☐ per month

Assets:

Savings/Checking Accounts: $ _____, Bank Name: _____, Account Number _____

Real Property: _____

Vehicle, Motorcycle, RV, Trailer, Boat, Other Property: _____

Name of the custodial parent _____ Home/Cell number _____

Address _____ SSN _____

Email address _____

Employer _____ Employer's phone number _____

Employer's address _____

PROVIDE PROOF OF INCOME AS LISTED BELOW:

☐ **EMPLOYED:** Gross monthly income: $_____

- At least 4 recent paystubs from all your current employers.

☐ **SELF-EMPLOYED:** Annual Gross Income: $_____ Annual Net Income: $ _____

- At least 2 years of income tax returns as well as a Profit/Loss Statement for the most recent quarter.

☐ **SOCIAL SECURITY INCOME:** Gross monthly income: $_____

- Copy of the award letter/s from the Social Security office.
- If the minor children are receiving auxiliary benefits, please provide proof.

☐ **VA BENEFIT/PENSION:** Gross monthly income: $ _____

- Copy of the award letter from the VA

☐ **RETIRED:** Gross monthly income: $ _____

- At least 2 most recent paystubs

☐ **UNEMPLOYMENT INCOME BENEFITS (UIB):** Weekly Benefits: $ _____ From the State of: _____

- Copy of the award letter from DETR

☐ **INABILITY TO WORK DUE TO ILLNESS OR INJURY:**

- Doctor's proof of your medical condition OR;
- Proof of worker's compensation benefit information including adjuster's name

☐ **LACK OF INCOME:** Explain how you are taking care of yourself without income. (Are you living with family/friends? Is your spouse/partner paying the bills? If more space is needed, continue on the back of this page)

_____

_____

REASON FOR MODIFICATION REQUEST:

☐ **CHANGE IN INCOME**. (Provide proof of income from all sources)

☐ **CHANGE IN CIRCUMSTANCE**: (Provide proof of income from all sources)

- ☐ EMANCIPATION: One or more children on my case have emancipated. (If the youngest child is turning 18 years of age within the next 6 months, we will not modify the order).
- ☐ HEALTH INSURANCE: **(You MUST provide proof of health insurance coverage and costs associated to cover each person (self, family and dependent children)**
- ☐ LEGALLY RESPONSIBLE TO SUPPORT ANOTHER MINOR CHILD/REN: **(You MUST provide proof of paternity for each additional child; A copy of birth certificate or a court order)**

☐ **INCARCERATED** (inmate number, facility and date of release) _____

☐ **Other** (provide proof) _____

I understand that once the application is made, I CANNOT stop the process. I also understand that my existing order(s) may increase, decrease or remain the same and that medical insurance for the child(ren) will be considered in the modified order. If my application is approved an appointment will be scheduled. I understand that failure to appear for this appointment may result in denial of my request. I understand that my application will be filed as an exhibit to the Motion to Modify or Notice and Finding.

By signing and returning this application with all supporting documentation, I am authorizing the District Attorney's Office to proceed with a review and adjustment of my order(s). If approved I agree to meet with the District Attorney Family Support Division and negotiate in good faith.

Sign _____ Date _____

FAILURE TO PROVIDE THE REQUIRED DOCUMENTS WILL RESULT

IN DENIAL OF YOUR REQUEST

HEALTH INSURANCE and DAY CARE COSTS

If you want the court to consider the health insurance costs and day care costs associated with the minor child(ren), you must provide the additional information specified below within 10 days of the date of this letter or attach the documents to your Review and Adjustment application:

FOR HEALTH INSURANCE COSTS:

- Breakdown of costs to cover each person (self, family and dependent child(ren) only)
- Proof of coverage and the type of coverage available
- List of all persons covered (self, spouse, and all dependent child(ren))

Note: This information can be obtained through your employer's Human Resources Department or Health Insurance Administrator.

FOR DAY CARE COSTS:

- Proof of recent payments (for at least 2 months) such as receipts or a written statement from the day care provider.

If our office does not receive the information noted above, the monthly health insurance premiums and/or the costs for day care for the minor child(ren) will not be considered.

Print Form