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: 702-366-2329 • TTY or relay services: 711

MARY-ANNE MILLER	CHRISTOPHER LALLI	ROBERT DASKAS	BRIGID J. DUFFY	KAREN S. CLIFFE
County Counsel	*Assistant District Attorney*	*Assistant District Attorney*	*Director DA Juvenile*	*Assistant DA of Family Support*

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.

You must **provide proof** of a **substantial** change of circumstances in order for this office to consider a modification of the child support order. For example, a child has emancipated, a new child needs to be added to the order, or the non custodial parent's gross monthly income has increased or decreased by at least 20%. Non-receipt of child support payments is NOT a change of circumstance or a reason for modification review.

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 child care costs, proof of health insurance coverage and costs 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.

Custodial Parent Review & Adjustment Application

(Each case requires a separate application)

Your name _____ Home/Cell Phone number _____

Address _____

SSN _____ Case Number _____

Email address _____

Employer _____ Employer's phone number _____

Employer's address _____

Health Insurance (provide proof of coverage and costs:

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

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

Please provide the requested information for each child covered by your order.

Child's name _____ Birth Date _____ SSN _____

Child's name _____ Birth Date _____ SSN _____

Child's name _____ Birth Date _____ SSN _____

Child's name _____ Birth Date _____ SSN _____

Child's name _____ Birth Date _____ SSN _____

Name of the non-custodial parent _____ Home/Cell Phone number _____

Address _____ SSN _____

Email address _____

Employer _____

Occupation _____ Employer's phone number _____

Employer's address _____

What kind of car does the non custodial parent own/drive? _____

Does the non custodial parent own a home or rent? _____

How many other children does the non custodial parent have? _____

REASON FOR MODIFICATION REQUEST:

***** If you have joint physical custody arrangement or court order, you must provide proof of your current income from all sources.***

☐ ***CHANGE IN INCOME***

☐ Non Custodial Parent's Income has changed: Explain. _____

_____

_____ . Provide proof, if available.

☐ Custodial Parent's Income has changed (for cases with shared/joint custody only): Explain.

_____

_____ . **Provide proof**

☐ ***CHANGE IN CIRCUMSTANCE***

☐ *Add or remove a child from this order:* _____

☐ *Emancipation* (If the child is turning 18 years of age within the next 6 months, we will not modify the order). **If the child will still be attending high school, you must provide school records.**

☐ *Health insurance:*

☐ Request for medical cash in lieu of health insurance coverage: **You MUST provide proof of health insurance coverage and cost associated to cover each person under the plan including self, self plus spouse, family and a dependent child only**

☐ Request to change the party required to provide

☐ I am ordered to provide health insurance; however

☐ It is no longer available.

☐ It is available but I am unable to afford coverage **(you <u>must</u> provide proof of costs with your application.)**

☐ I request both parties be required to provide health insurance.

☐ ***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.

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

Sign _____ Date _____

<u>FAILURE TO PROVIDE THE REQUIRED DOCUMENTS MAY DELAY THE PROCESS OR MAY RESULT IN DENIAL OF YOUR REQUEST</u>

HEALTH INSURANCE and CHILD CARE COSTS

If you want the court to consider the health insurance costs and child 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 CHILD CARE COSTS:

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

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