



Child Support Enforcement Agency
Corey Clark, Director

• 239 West Main Street, Lancaster, Ohio 43130
• (740) 687-7155 • www.fcjfs.org

DATE: _____

OBLIGOR: _____

OBLIGEE: _____

CASE NO.: _____

An Administrative Adjustment Review may be requested by either party to a child support case. This review may result in a recommendation for an increase, decrease, or no change in the current child support order. If you would like to request a review, please complete the attached documents and return them to the Fairfield County Child Support Enforcement Agency (CSEA).

The Administrative Adjustment Review Application Form must be signed before a Notary Public. Please read it carefully so that you understand your rights and responsibilities. Notary services are provided free of charge at the CSEA.

As a general rule, the CSEA may review an order at the request of either party so long as thirty-six (36) months have passed from the date of the original order or the date of the most recent review.

Certain circumstances warrant a review BEFORE the standard thirty-six (36) month time frame (see #1- #10 below). If less than thirty-six (36) months have passed since your last review, PLEASE CHECK MARK THE APPROPRIATE BOX EXPLAINING YOUR REASON FOR REQUESTING A MODIFICATION.

- 1. The minimum amount of support was ordered (usually \$50.00 per month) based on the unemployment or underemployment of the obligor and proof is obtained that the obligor has moved from being unemployed to employed, or has changed from being underemployed to more gainfully employed.
- 2. Either party has experienced a loss of employment for a period of at least six (6) months. The loss of employment is shown to be beyond the party's control and is reasonably expected to continue for an extended period of time.
- 3. Either party becomes permanently disabled, reducing his or her earnings ability. The disability must be medically verified by the receipt of Social Security Disability benefits and/or a physician's complete diagnosis and determination.



- 4. Either party to the order cannot pay support for the duration of the child's minority because of institutionalization or incarceration with no chance of parole, and no income or assets are available to the party which could be levied or attached for support.
- 5. Either party has experienced a 30% change in gross income or income producing assets for a period of at least six (6) months. A decrease in income must be shown to be beyond the party's control and is reasonably expected to continue for an extended period of time.
- 6. One or more of the children in the order have been deleted from the order because of emancipation or other reasons.
- 7. A need to access the availability of health insurance or improved health insurance exists regardless of whether an adjustment in the amount of child support ordered is necessary.
- 8. The current support order deviated from the guideline amount and the reason for the deviation no longer exists.
- 9. You are the obligor and you have been called to active military service in the uniformed services.
- 10. You are the obligor and have provided CSEA with information regarding notice of the date of termination of your active military service, and you can provide written documentation sufficient to establish that your current employer has violated the Uniformed Services Employment and Reemployment Rights Act.

Along with your request for a review, you must send to the CSEA the required documentation to support the circumstance that applies to your case. Again, one of the above ten circumstances must exist to *permit* the CSEA to review the case prior to the standard thirty six (36) month time frame.

If you have any questions about the Administrative Adjustment Review process or the documentation required, please call me at (740) 687-7155.

Sincerely,

Case Manager Assistant
Fairfield County JFS, CSEA



ADMINISTRATIVE ADJUSTMENT REVIEW APPLICATION FORM

I am requesting that the Fairfield County Child Support Enforcement Agency (C.S.E.A.) conduct an Administrative Adjustment Review of my child support order. I understand that:

1. The review will take place at least 45 days after the determination that a review should be conducted. The completed process may take as long as six (6) months, depending upon requested administrative or court hearings by either party.
2. In the event the review reveals an increase or decrease in the amount of child support, to which I am opposed, the CSEA will continue to pursue the Administrative Adjustment.
3. Upon completion of the review, the CSEA is only permitted to recommend a change in the amount of child support when the recalculated amount has increased or decreased by more than ten percent (10%).
4. The client of the CSEA and its legal representative is the State of Ohio, whose interest in this matter is the best interest of the child(ren).
5. As a recipient of IV-D child support services, I am subject to all IV-D services available, including all enforcement remedies of the child support program.

By my signature below, I affirm that I understand and accept the above conditions and that I request the CSEA to review my child support order.

SIGNATURE

Sworn to and subscribed before me this _____ day of _____ 20_____.

NOTARY PUBLIC



PARENT INFORMATION

OBLIGOR'S NAME: _____

ADDRESS: _____

TELEPHONE: HOME: _____ WORK: _____

SOC SEC NO: _____ DATE OF BIRTH: _____

PRESENT EMPLOYER:

NAME: _____ TELEPHONE: _____

ADDRESS: _____

PAID (circle one): WEEKLY/ BI-WEEKLY /TWICE MONTHLY/ MONTHLY

OBLIGEE'S NAME: _____

ADDRESS: _____

TELEPHONE: HOME: _____ WORK: _____

SOC SEC NO: _____ DATE OF BIRTH: _____

PRESENT EMPLOYER:

NAME: _____ TELEPHONE: _____

ADDRESS: _____

PAID (circle one): WEEKLY/ BI-WEEKLY /TWICE MONTHLY/ MONTHLY

CHILDREN IN WHICH SUPPORT IS BEING COLLECTED IN THE ABOVE CASE

NAME: 1. _____ SS# _____ AGE _____ DOB _____

2. _____ SS# _____ AGE _____ DOB _____

3. _____ SS# _____ AGE _____ DOB _____

4. _____ SS# _____ AGE _____ DOB _____



HEALTH BENEFITS DATA FORM

ASSIGNMENT OF SUPPORT RIGHTS (ADC, IV-E, MEDICAID): YES _____ NO _____

POLICY HOLDER'S NAME: _____ SSN: _____

MONTHLY PAYROLL DEDUCTION: INDIVIDUAL \$ _____ FAMILY \$ _____

INSURANCE COMPANY:

NAME: _____ TELEPHONE: _____

ADDRESS: _____

INDIVIDUAL PLAN # _____ GROUP PLAN # _____

POLICY ID # _____ GROUP # _____

EFFECTIVE DATE OF HEALTH INSURANCE COVERAGE _____

BEGINNING: _____ ENDING: _____

HEALTH PLAN SERVICE AREA: _____

SPAN OF CURRENT ENROLLMENT: _____

NAME OF DEPENDENT CHILDREN	DOB#	ENROLLMENT DATES	
		OPEN	CLOSE
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

ADDITIONAL HEALTH INSURANCE/ INCLUDE NAME, ADDRESS, & TELEPHONE NUMBER

VISION: _____

DENTAL: _____

PRESCRIPTION: _____

In accordance with ORC 3113.217 (C) (11), please provide this agency with any brochures, or information pamphlets regarding the employee's current health & medical benefits. In accordance with ORC 3113.217 (F), please notify the CSEA when the employee changes or terminates health & medical benefits.

Enclose Copy of Health Insurance Card, (front & back)