



## HOW TO ASK FOR A REVIEW OF YOUR CHILD SUPPORT ORDER

If you want us to review and possibly change of your child support order:

1. Fill out the Review and Adjustment packet. It includes:
  - Request for Review and Adjustment form
  - Financial Statement form
2. Send your completed forms and any required documents:
  - Take a photo or scan them.
  - Email to [askdcse@dss.virginia.gov](mailto:askdcse@dss.virginia.gov), or
  - Upload them through our child support portal <https://mychildsupport.dss.virginia.gov>

A caseworker will contact you to confirm we got your documents and let you know if we need more information.

For more get case or payment information, go to <https://mychildsupport.dss.virginia.gov> .



### REQUEST FOR REVIEW AND ADJUSTMENT

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

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\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

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

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

Email Address: \_\_\_\_\_



### 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<br>(Court or<br>Administrative) | Payee<br>(Person you pay) | Ordered Amount<br>(\$ amt and pay<br>frequency) | Total Amount Paid<br>(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 | \$<br>Amount/Frequency | Paid to/Received<br>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 2<sup>nd</sup> 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 |
|-------------------|----------|-------------|-----------|--|-----------------|
| _____             | _____    | _____       | _____     | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____           |
| _____             | _____    | _____       | _____     | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____           |
| _____             | _____    | _____       | _____     | <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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Signature

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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.