

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

*apt.*

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Best Time to Contact You: ☐ Daytime ☐ Evening

Public Assistance Case Number(s): \_\_\_\_\_

Child Support Case ID Number(s): \_\_\_\_\_

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**Documentation:** You must attach a copy of the SCU/SSD desk review determination letter and any additional but previously unavailable documentation in support of your claim that distribution was incorrect. Please confirm this by checking the appropriate boxes:

- ☐ I have attached a copy of the SCU/SSD determination and it is dated within 20 calendar days of this request.
- ☐ I have also attached additional documentation to support my claim which was previously unavailable.

signature of person requesting second-level desk review

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print name of person requesting desk review

\_\_\_\_\_

date

New York State Division Child Support Enforcement  
ATTN: Bureau of Program Operations, Second-Level Desk Review  
40 N. Pearl Street, 13<sup>th</sup> Floor  
Albany, New York 12243-0001