

**Additional Child Information (Application)**

To be completed when the Applicant has **more than two (2) children** with the Other Party named in this application.

**Submit with Part A and Part B of the LDSS-5143**

**Name of Child #**

First Middle Last Suffix

**SSN/ITIN****Gender**

Female Male Non-Binary/Other

**Date of Birth (Month/Day/Year)****Due Date**

Unborn

**Name of Parent**

Parent 1 First Middle Last

Parent 2 First Middle Last

**Child's Birthplace**

Hospital City State Country

**Other Party's Relationship to the Child**

Parent Stepparent Alleged Father

**Parents' Marital Status**

Were the parents listed above married at or after the time of the child's birth?

Yes, to each other Yes, but not to each other No Unknown

If **Yes, to each other**, go to the **Order of Support Information** questions. **Otherwise**, go to the **Paternity Establishment** questions.

**Paternity Establishment**

Was paternity established?

Yes - Complete the **Paternity Establishment** questions.

No - Go to the **State of Jurisdiction** questions.

You **do not** need to complete the **State of Jurisdiction** questions.

Unknown - Go to the **State of Jurisdiction** questions.

How was paternity established?

Established in Court on Name of Court

Acknowledgment of Paternity on

In what county, state, and country was paternity established?

County State Country

Where was the child conceived? State Country

**State of Jurisdiction**

Did the alleged father (AF) provide prenatal expenses or support for the child? Yes No Unknown

Did the AF reside with the child in New York State? Yes No Unknown

Does the child reside in New York State as the result of acts or directives of the AF? Yes No Unknown

**Order of Support Information**

Is there an order of support for this child? Yes No Unknown If "Yes," what is the date of the order?

Is health insurance ordered? Yes No Unknown

**Obligation Amount**

\$ Weekly Every two weeks Monthly Twice per month Other

**Court that Issued the Order**

Family Supreme Other

County State Country

**Health Care Coverage Information**

Does the child have health care coverage? Yes No Unknown

If "Yes," identify the type of coverage: Private - Go to **Health Insurance Benefits** questions.

Public - Go to **Public Health Care Coverage** questions.

**Health Insurance Benefits**

Who provides the child's private health care coverage?

Custodial Parent Guardian Noncustodial Parent/ Alleged Father Stepparent Unknown Other

Name of Health Insurance Carrier Policy # Group #

Street Floor/Apt./Suite City State ZIP

**Public Health Care Coverage**

Indicate the type of public health care coverage:

Medicaid Child Health Plus (CHPlus) CHPlus monthly contribution: \$

Other