

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ECONOMIC SERVICES ADMINISTRATION (ESA)
DIVISION OF CHILD SUPPORT (DCS)

Address Disclosure Request
(RCW 26.23.120 and WAC 388-14A-2107)

Instructions

Complete this form and return it to the Division of Child Support (DCS) address listed on page 2.

1. If you mail or fax this form to DCS, you must have it notarized.
2. If you personally deliver this form to DCS, you do not have to have it notarized. You will have to provide DCS with identification that proves you are the person who signed the form.
3. If your attorney signs and mails or faxes this form to DCS, your attorney does not have to have it notarized.

Mark the boxes below that apply to your request. **Except for your signature, print all responses. Use blue or black ink only.**

Request

1. I request the last-known address of the other party (named below) to my child support order. I need this information to establish, enforce, or modify a support order in court.
2. I request the last-known employer address for the other party (named below) to my child support order. I need this information to establish, enforce, or modify a support order in court.
3. I request the last-known address of the children listed below to enforce the visitation rights, custody, or residential time provisions of my court order. There is no court order restricting my visitation, custody, or residential rights.
 - a. I already gave DCS a copy of the most recent court order. This order grants me visitation, custody, or residential rights. My rights have not changed since entry of this order.
 - b. I attached a copy of the most recent court order. This order grants me visitation, custody, or residential rights. My rights have not changed since entry of this order.
4. I request the last-known address of the other party (named below) to my child support order. I need this information to establish a parenting plan for the children listed below

MY FULL NAME

MY PO BOX OR STREET ADDRESS

MY SOCIAL SECURITY NUMBER

MY CITY STATE ZIP CODE

FULL NAME OF THE OTHER PARTY TO MY SUPPORT ORDER/
CHILDREN'S CUSTODIAN

()

MY TELEPHONE NUMBER (INCLUDE AREA CODE)

CHILD'S NAME

CHILD'S NAME

CHILD'S NAME

CHILD'S NAME

CHILD'S NAME

CHILD'S NAME

Signature

I understand that Washington State law does not allow me to give the information requested on page 1 to anyone except as needed to take the legal action for which I requested it.

DATE

MY SIGNATURE OR MY ATTORNEY'S SIGNATURE

Notarization

State of _____

County of _____

Signed or affirmed before me on _____ by _____.

SIGNATURE

TITLE

My appointment expires _____

Mail completed form to:
DIVISION OF CHILD SUPPORT
PO BOX 11520
TACOMA WA 98411-5520
Within Olympia calling area (360) 664-5000
Outside Olympia calling area (800) 457-6202
Fax: 866-668-9518
TTY/TDD services available for the speech or hearing impaired.
Visit our web site at: www.dshs.wa.gov/esa/division-child-support

In reply, refer to case numbers:

No person because of race, color, national origin, creed, religion, sex, age, or disability, shall be discriminated against in employment, services, or any aspect of the program's activities. This form is available in alternative formats upon request.