



K# \_\_\_\_\_

# Child Support Services Paternity Questionnaire to be Completed by the Birth Parent

BIRTH PARENT INFORMATION				
First Name:		Middle Name:	Maiden Name:	Last Name:
Social Security Number (SSN):			Date of Birth (DOB):	
Have you ever been married? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how many times? _____ Please provide the following for each marriage:				
Date of marriage: _____		Spouse name: _____		
Date of marriage: _____		Spouse name: _____		
Date of marriage: _____		Spouse name: _____		
Have you ever been divorced? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide the following:				
Court order: _____		County: _____	State: _____	Date of divorce: _____ Name of spouse: _____
Court order: _____		County: _____	State: _____	Date of divorce: _____ Name of spouse: _____
Court order: _____		County: _____	State: _____	Date of divorce: _____ Name of spouse: _____
Have you lived outside of Kansas? <input type="checkbox"/> No <input type="checkbox"/> Yes, list where and dates: _____				
Who lives in your home currently: _____				
DEPENDENT #1 INFORMATION				
Dependent Name (First, Middle, Last):			DOB:	SSN:
Did anyone say they were the child's parent at the child's birth? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide names: _____				
Did anyone sign anything at the child's birth? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide names: _____				
Has anyone said they are the child's parent to your family or community? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide name: _____				
How many sexual partners did you have 30 days before and 30 days after you became pregnant? _____				
Please tell us what you know about each sexual partner				
1	First Name:	Middle Name:	Last Name:	DOB/approximate age:
Date of intercourse: _____		What city and state did you have sexual intercourse? _____		
Do you remain in contact with this person? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Do you have an address and/or phone number for them? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide: _____				
Do you have social media information for this person? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list type: _____				
2	First Name:	Middle Name:	Last Name:	DOB/approximate age:
Date of intercourse: _____		What city and state did you have sexual intercourse? _____		
Do you remain in contact with this person? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Do you have an address and/or phone number for them? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide: _____				
Do you have social media information for this person? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list type: _____				
3	First Name:	Middle Name:	Last Name:	DOB/approximate age:
Date of intercourse: _____		What city and state did you have sexual intercourse? _____		
Do you remain in contact with this person? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Do you have an address and/or phone number for them? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide: _____				
Do you have social media information for this person? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list type: _____				
DEPENDENT #2 INFORMATION				
Dependent Name (First, Middle, Last):			DOB:	SSN:
Did anyone say they were the child's parent at the child's birth? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide names: _____				
Did anyone sign anything at the child's birth? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide names: _____				
Has anyone said they are the child's parent to your family or community? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide name: _____				
How many sexual partners did you have 30 days before and 30 days after you became pregnant? _____				
Please tell us what you know about each sexual partner				
1	First Name:	Middle Name:	Last Name:	DOB/approximate age:

Date of intercourse:		What city and state did you have sexual intercourse?	
Do you remain in contact with this person? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Do you have an address and/or phone number for them? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide: _____			
Do you have social media information for this person? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list type: _____			
2	First Name:	Middle Name:	DOB/approximate age:
Date of intercourse:		What city and state did you have sexual intercourse?	
Do you remain in contact with this person? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Do you have an address and/or phone number for them? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide: _____			
Do you have social media information for this person? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list type: _____			
3	First Name:	Middle Name:	DOB/approximate age:
Date of intercourse:		What city and state did you have sexual intercourse?	
Do you remain in contact with this person? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Do you have an address and/or phone number for them? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide: _____			
Do you have social media information for this person? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list type: _____			
<b>DEPENDENT #3 INFORMATION</b>			
Dependent Name (First, Middle, Last):		DOB:	SSN:
Did anyone say they were the child's parent at the child's birth? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide names: _____			
Did anyone sign anything at the child's birth? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide names: _____			
Has anyone said they are the child's parent to your family or community? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide name: _____			
How many sexual partners did you have 30 days before and 30 days after you became pregnant? _____			
Please tell us what you know about each sexual partner			
1	First Name:	Middle Name:	DOB/approximate age:
Date of intercourse:		What city and state did you have sexual intercourse?	
Do you remain in contact with this person? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Do you have an address and/or phone number for them? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide: _____			
Do you have social media information for this person? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list type: _____			
2	First Name:	Middle Name:	DOB/approximate age:
Date of intercourse:		What city and state did you have sexual intercourse?	
Do you remain in contact with this person? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Do you have an address and/or phone number for them? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide: _____			
Do you have social media information for this person? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list type: _____			
3	First Name:	Middle Name:	DOB/approximate age:
Date of intercourse:		What city and state did you have sexual intercourse?	
Do you remain in contact with this person? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Do you have an address and/or phone number for them? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide: _____			
Do you have social media information for this person? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list type: _____			
<b>BIRTH PARENT'S AFFIRMATION AND AGREEMENT</b>			
I hereby swear and affirm under the penalties of perjury that the information contained in this questionnaire is true and correct to the best of my knowledge. Providing false information could result in perjury charges being filed against me.			
Printed Name of Birth Parent		Signature of Birth Parent X _____	Date Signed (mm/dd/yyyy)
Printed Name of Parent/Guardian (if mother is an unemancipated minor)		Signature of Parent/Guardian (if applicant is an unemancipated minor) X _____	Date Signed (mm/dd/yyyy)

If you need assistance with this questionnaire call Child Support Services at (888) 757-2445 or visit your nearest Child Support Office found at <http://www.dcf.ks.gov/services/CSS/Pages/Contractor-Information.aspx>. Please send this questionnaire to Child Support Services by mail PO Box 552 Lawrence, Kansas 66044; fax 844-682-2171; or email [dcf.cssapplications@ks.gov](mailto:dcf.cssapplications@ks.gov)