OFFICE OF
CHILD SUPPORT ENFORCEMENT
Administration for Children & Families

STATE REQUEST FOR PSOC LOCATE SERVICES

Project Save Our Children

State of *_____ County of ____

IV-D Case Number * _________

For OCSE PSOC Use
Date Case Received (mm/dd/yyyy)

PSOC Case Number

SECTION 1 – PAYER INFORMATION

Name of Payer * Last / First / Middle		Social Security Number*	Date of Birth* (mm/dd/yyyy) Place of Birth
Last Known Address (Street Name and Number)			Telephone Number(s):
City	State & Zip Code		Was the address verified? If so, when (mm/dd/yyyy)
Employer Name	Employer Address		Telephone Number
Wage and Income History	Date Verified (mm/dd/yyyy)		Source of Verification
Occupation	Professional License		Auto & Driver's License / State Issued
Alias	Does the payer have any current warrants? If yes, please indicate type and where issued.		

SECTION 2 – REFERRAL INFORMATION* (This section must be filled out completely.)

State County	Name of Referring Agency	Referral Date (mm/dd/yyyy)
State Contact Person	Direct Telephone Number	FAX
Address of Referring Agency (Street Name and Number)		Email Address
City	State	Zip Code

STATE REQUEST FOR PSOC LOCATE SERVICES

IV-D Case Number * __________

SECTION 3 – REFERRAL* (This section must be filled out completely.)

SIGNATURE OF AUTHORIZED OFFICIAL

The referring IV-D agency certifies that this referral is being made as part of an investigation for an interstate child support case that appears to be appropriate for criminal non-support action and the state has exhausted all state and FPLS locate resources. The locate information sought in this IV-D case is for an authorized user and an authorized purpose.

By ____ Date _______________ (mm/dd/yyyy)

NAME: ____________________________________ TITLE: ______________________________

Mail the referral via **secured mail service** (such as FedEx) to the following:

OCSE PSOC Coordinator - Locate Services

Office of Child Support Enforcement
Administration for Children and Families
U.S. Department of Health and Human Services

330 C Street, SW, 5th Floor
Washington, DC 20201

Or

Fax: (202) 478-0051

Please be sure to provide a return fax number in your referral form.

Or

Using an encrypted email function, email to PSOC@acf.hhs.gov

DO NOT include Instructions

* MANDATORY – SECTION MUST BE COMPLETED

STATE REQUEST FOR PSOC LOCATE SERVICES

Instructions

The referring IV-D agency must certify that the referral is being made as part of an investigation for an interstate child support case that appears to be appropriate for criminal non-support action and that the state has exhausted all state and FPLS locate resources. The locate information sought in this IV-D case is for an authorized user and an authorized purpose.

Upon receipt of the referral, the OCSE PSOC Locate Coordinator will search the Social Security Administration Data Acquisition Retrieval System (SSADARS) for asset information and provide the results of these searches to the requesting state. The state should expect to receive results within two (2) weeks of the request date. In the event of a delay, the OCSE PSOC Locate Coordinator will notify the State PSOC Coordinator of the reason.

This template and instructions will assist you in filling out the PSOC referral quickly and easily. You may still choose to print this form and handwrite the referral. If you handwrite the referral, please print legibly.

This referral is in a template form. Please refrain from altering the form. The areas marked with an asterisk (*) are required fields that must be filled in.

TOP SECTION – STATE REQUEST FOR LOCATE SERVICES

State:*	Enter the abbreviation for the state that is submitting the referral.
County:	If the referral originated from a county, enter the name of the county.
IV-D Case Number:*	Enter the state IV-D case number (on both pages).

SECTION 1 – PAYER INFORMATION

Name of Payer:*	Enter the last name, press the tab button, enter the first name, and enter the middle initial.
Social Security Number:*	Enter the SSN in the format of 000-00-0000
Date of Birth:*	Enter the month, day and year in MM/DD/YYYY format. (Example: March 14, 1957 should be 03/14/1957)
Place of Birth:	Enter the name of the city and state where the payer was born if known.
Last Known Address:	Enter the last known address for the payer. Enter the street address and apartment number.
Telephone Number:	Enter the last known telephone number of the payer. Format 000-000-0000.
City:	Enter the last known city of residence.
State and Zip Code:	Enter the state's abbreviation and zip code of the last known address of the payer.
Was the address verified?:	If address was verified through mail coverings, post office verifications, etc., enter the verification date. Format MM/DD/YYYY.
Employer Name:	Enter the payer's last known employer or company name.
Employer Address:	Enter the employer's address to include city, state and zip code, if known.
Telephone Number:	Enter the employer's telephone number, if known.
Wage/Income History:	Enter income/wage history (verified).
Date Verified:	Enter the date annual wage information was verified.
Source of Verification:	Enter the source(s) of verification.
Occupation:	Enter the payer's occupation. (e.g., construction, sales)
Professional License:	Enter the type of license that the payer may have, such as doctor, nurse, contractor, etc.

STATE REQUEST FOR PSOC LOCATE SERVICES

Auto & Driver's License/State Issued:	Enter the driver's license information of the payer, if known. (If only the state is known, please enter it.)
Alias:	Enter the aliases or names that the payer may have used or is currently using.
Does the Payer have any outstanding warrants?:	Enter the type of warrant and the state or jurisdiction that issued the warrant, if known.

SECTION 2 – REFERRAL INFORMATION * (This section must be filled out completely.)

State / County:	Enter the abbreviation for the state that is submitting the referral. If the referral originated from a county, enter the name of the county.
Name of Referring Agency:	Enter the name of the referring state IV-D agency.
Referral Date:	Date that the referral is received made / sent to PSOC.
State Contact Person:	Enter the name of a person that can be contacted if the PSOC Locate Coordinator has questions concerning the referral
Direct Phone Number:	Enter the telephone number for the contact person.
FAX:	Enter the fax number for the contact person.
Address of Referring Agency:	Enter the mailing street address of the contact person that will receive the case after the case has been processed.
Email Address:	Enter the contact person's email address.
City:	Enter the city of the contact person.
State:	Enter the state of the contact person.
Zip Code:	Enter the mailing zip code of the contact person.

SECTION III – REFERRAL * (This section must be filled out completely.)

SIGNATURE OF AUTHORIZED OFFICIAL

In this section, the agency certifies that this referral is being made as part of an investigation for an interstate child support case that appears to be appropriate for criminal non-support action and that all state and FPLS locate efforts have been exhausted and that the locate request is made for an authorized purpose and by an authorized person under Title IV-D of the Social Security Act.

The state official making the referral must sign; the referral will be made by the State PSOC Coordinator's office.

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