JUDY BRANHAM
EXECUTIVE DIRECTOR

CONNIE MORENO
OPERATIONS MANAGER

DOMESTIC RELATIONS OFFICE
500 E. San Antonio Ave, RM LL-108
El Paso, TX 79901
Phone: (915) 834-8200
Fax: (915) 834-8299

CRITERIA FOR ACCEPTANCE OF AN ENFORCEMENT CASE BY THE DRO

The El Paso County Domestic Relations Office will enforce court orders for child support and visitation through the "Friend of the Court" program. When the DRO accepts an application for enforcement, the DRO does not represent the applicant, nor the respondent. The DRO represents only the interests of the court that rendered the order as the "Friend of the Court." Each party to the case has the right to hire an attorney to represent him or her in any court action that may be taken by the DRO. Any person that is a party to a case may apply for services through the Friend of the Court program, as long as the following criteria are met:

1) the order to be enforced was issued by an El Paso court, or has already been transferred to El Paso if it was originally issued by a court outside of El Paso;
2) There is no litigation pending;
3) The obligee (for a child support case) is not receiving welfare (and has not otherwise assigned support rights to the State of Texas or the Attorney Generals' Office), and the case is not already an Attorney General/Title IV-D case;
4) There is a FINAL order for either child support or visitation in place (this includes divorce decrees, modification orders, paternity decrees or orders establishing the parent-child relationship, and protective orders, but not temporary orders) attached to this order;
5) Applicant is current in payment of the annual service fee and any other DRO fees.

If you wish to apply for services with the Enforcement Division of the DRO, please complete an application (currently available at the DRO offices and on the DRO website, www.epcounty/dro) and return it to the DRO along with a copy of each pertinent court order. You will be notified in writing of the DRO's acceptance of your case, and any actions taken by the office.

NOTICE:

If the respondent lives out of town, the applicant will be required to pay the costs of serving the respondent (usually about $175.00, but it varies with location). If the applicant lives out of town, they may be required to attend a hearing or hearings in El Paso.

I certify that I have read, understood and agree to abide by the terms of these criteria.

_____
APPLICANT SIGNATURE

EL PASO COUNTY DOMESTIC RELATIONS OFFICE
500 E. SAN ANTONIO STREET, ROOM LL108
EL PASO, TEXAS 79901
(915)834-8200 HOURS: 8:00AM – 4:30 PM

FOR INTERNAL USE ONLY
Receipt No.: _____
Amount Paid: _____
Date Paid: _____
Submitted by: Mail / Walk-in / E-mail
Received by _____
Date Received: _____

APPLICATION TO ENFORCE CHILD SUPPORT AND/OR MEDICAL SUPPORT

NOTE: A MOTION TO ENFORCE AN ORDER BY CONTEMPT MAY RESULT IN THE PAYOR BEING INCARCERATED IN THE EL PASO COUNTY JAIL.

PLEASE READ THE **"CRITERIA FOR ACCEPTANCE OF A CASE BY THE DRO"** ATTACHED TO THIS APPLICATION BEFORE SUBMITTING THE APPLICATION. THE APPLICATION FEE IS **NOT REFUNDABLE**.

CAUSE NO.:_____

GENERAL INFORMATION

IT IS THE POLICY OF THIS OFFICE TO ATTEMPT TO RESOLVE CHILD SUPPORT DISPUTES BY SENDING TO THE PAYOR A COMPLAINT LETTER. THE LETTER ADVISES THE PAYOR THAT A COMPLAINT HAS BEEN RECEIVED BY THE **DOMESTIC RELATIONS OFFICE** THAT CHILD SUPPORT IS NOT BEING PAID AS ORDERED. THE PAYOR IS ADVISED FURTHER THAT UNLESS THE PAYOR CONTACTS THE **DOMESTIC RELATIONS OFFICE** WITHIN **FIFTEEN** (15) DAYS OF RECEIPT OF THE COMPLAINT LETTER AND THE DISPUTE IS SOLVED, A MOTION TO ENFORCE CHILD SUPPORT BY CONTEMPT AND WITHHOLD FROM EARNINGS MAY BE FILED.

EVERY REASONABLE EFFORT WILL BE MADE TO RESOLVE THE CHILD SUPPORT DISPUTE WITHOUT COURT ACTION. IF COURT ACTION IS NECESSARY, BE ADVISED THAT EL PASO COUNTY CANNOT PAY THE COST OF OUT OF TOWN SERVICE. THE APPLICANT WILL BE RESPONSIBLE FOR THE COSTS OF SERVICE (which may be recovered in the enforcement case) AND MUST SUBMIT A $175 PROCESS SERVICE DEPOSIT WITH THIS APPLICATION.

COURT COSTS MUST BE PAID BY THE APPLICANT **BEFORE** A MOTION TO ENFORCE CHILD SUPPORT ORDER BY CONTEMPT AND WITHHOLD FROM EARNINGS WILL BE FILED. A COST LIST IS ENCLOSED WITH THIS APPLICATION. COURT COSTS INCLUDE THE ANNUAL CHILD SUPPORT SERVICE FEE OF THE EL PASO COUNTY **DOMESTIC RELATIONS OFFICE**, AND IF APPLICABLE, THE FILING FEE FOR THE MOTION TO LIFT STAY. EVERY REASONABLE EFFORT WILL BE MADE TO RESOLVE THE CHILD SUPPORT DISPUTE WITHOUT COURT ACTION.

INFORMATION ABOUT PARTIES – (PLEASE PRINT)

INFORMATION ON PERSON APPLYING FOR SERVICES – (PAYEE):

NAME: _____ SOCIAL SECURITY NO.: _____

ADDRESS: _____ DRIVER'S LICENSE NO.: _____STATE_____

CITY: _____ STATE_____ZIP_____

HOME PHONE: (_____) _____ DATE OF BIRTH: _____

E-MAIL ADDRESS: _____

EMPLOYER: _____ WORK PHONE: (_____)_____HOURS: _____

ADDRESS:_____ CITY:_____STATE:_____ _ZIP:_____

INFORMATION ON PERSON ORDERED TO PAY CHILD SUPPORT – (PAYOR):

NAME:_____ SOCIAL SECURITY NO.:_____

ADDRESS:_____ DRIVER'S LICENSE NO.:_____STATE_____

CITY: _____ STATE_____ZIP_____

HOME PHONE:(_____) _____ DATE OF BIRTH:_____

E-MAIL ADDRESS: _____

EMPLOYER:_____ WORK PHONE:(_____)_____HOURS:_____

ADDRESS:_____ CITY:_____STATE:_____ZIP:_____

ALIASES/NICKNAMES :_____ HAIR COLOR:_____EYE COLOR: _____

RACE :_____SEX:_____ HEIGHT:_____WEIGHT:_____

CRIMINAL HISTORY OF BOTH PARTIES: (INCLUDE PROTECTIVE AND/OR RESTRAINING ORDERS AND ANY PROBATION ORDERS _____

PHYSICAL DESCRIPTION OF PAYOR: (TATOOS, BEARD, SCARS, GLASSES, ETC.) ______________________________________

____

AUTOMOBILE MAKE: ______________________ MODEL: _______________________YEAR: ____________________

COLOR:____________TAG NO._____________ OTHER INFORMATION:___________________________________

ADDITIONAL INFORMATION/OTHER LOCATIONS WHERE SERVICE MAY BE ATTEMPTED:_____________________________

____

CHILDREN INFORMATION

NAME:__________________________________ SOCIAL SECURITY NO.:__________________________________

ADDRESS:_______________________________ DATE OF BIRTH:______________ PLACE___________________

____ SEX:__________GRADUATION DATE:_____________________

NAME:__________________________________ SOCIAL SECURITY NO.:__________________________________

ADDRESS:_______________________________ DATE OF BIRTH:_______________PLACE___________________

____ SEX:__________GRADUATION DATE:_____________________

NAME:__________________________________ SOCIAL SECURITY NO.:_________________________________

ADDRESS:_______________________________ DATE OF BIRTH:_______________PLACE__________________

____ SEX:__________GRADUATION DATE:_____________________

NAME:__________________________________ SOCIAL SECURITY NO.:_________________________________

ADDRESS:_______________________________ DATE OF BIRTH:_______________PLACE__________________

____ SEX:__________GRADUATION DATE:_____________________

NAME:__________________________________ SOCIAL SECURITY NO.:_________________________________

ADDRESS:_______________________________ DATE OF BIRTH:_______________PLACE__________________

____ SEX:__________GRADUATION DATE:_____________________

NAME:__________________________________ SOCIAL SECURITY NO.:_________________________________

ADDRESS:_______________________________ DATE OF BIRTH:________________PLACE___________________

____ SEX:__________GRADUATION DATE:_____________________

COURT-ORDERED CHILD SUPPORT INFORMATION

NAME OF FINAL ORDER IN WHICH CURRENT CHILD SUPPORT WAS ESTABLISHED – **DO NOT INCLUDE TEMPORARY ORDERS**:

____

DATE ORDER WAS SIGNED:_________________ IS ORDER AN EL PASO COUNTY ORDER?_________________

IF OTHER THAN EL PASO COUNTY WHERE? IF OTHER THAN EL PASO COUNTY ORDER, HAS ORDER BEEN

____ TRANSFERRED TO EL PASO COUNTY?___________________

HAS AN ORDER TO WITHHOLD CHILD SUPPORT FROM EARNINGS BEEN SENT TO PAYOR’S EMPLOYER?_____________

IS CHILD SUPPORT CURRENTLY BEING DEDUCTED FROM THE PAYOR’S EARNINGS?_______________________________

IS PAYOR CURRENTLY ON PROBATION IN EL PASO COUNTY FOR FAILURE TO PAY CHILD SUPPORT?_______________

HAS AID FOR DEPENDENT CHILDREN (AFDC/TANF/SNAP) EVER BEEN PAID FOR THE SUBJECT CHILDREN?___________

HAS PAYOR PREVIOUSLY BEEN HELD IN CONTEMPT FOR FAILURE TO PAY CHILD SUPPORT?______________________

HAS PAYOR FILED BANKRUPTCY SINCE THE FINAL ORDER WAS SIGNED?____

IF YES, A COPY OF THE BANKRUPTCY PETITION MUST BE PROVIDED.

NOTE: IF A BANKRUPTCY PETITION IS CURRENTLY PENDING, A MOTION TO ENFORCE CHILD SUPPORT BY CONTEMPT MAY NOT BE FILED UNTIL PERMISSION IS OBTAINED FROM THE BANKRUPTCY COURT. A MOTION TO LIFT STAY MUST BE FILED WITH THE BANKRUPTCY COURT TO BE ABLE TO ENFORCE YOUR CHILD SUPPORT ORDER. IF A BANKRUPTCY PETITION IS FILED AFTER A MOTION TO ENFORCE CHILD SUPPORT IS FILED, A MOTION TO LIFT STAY MUST BE FILED WITH THE BANKRUPTCY COURT IN ORDER TO CONTINUE.

HAS THE BANKRUPTCY BEEN DISCHARGED?_____ IF YES, A COPY OF THE DISCHARGE MUST BE PROVIDED.

HAS ANY CHILD BEEN WITH THE PAYOR FOR ANY LENGTH OF TIME THAT EXCEEDS COURT-ORDERED VISITATION?

_____

IF YES, LIST EACH CHILD'S NAME AND SPECIFIC DATES:

CHILD'S NAME BEGINNING DATE ENDING DATE

_____

_____

_____

CHILD SUPPORT ARREARAGE INFORMATION

HAVE CHILD SUPPORT PAYMENTS BEEN PAID THAT WERE NOT PAID THROUGH THE TEXAS CHILD SUPPORT STATE DISBURSEMENT UNIT? _____YES _____ NO

IF YES, PLEASE REQUEST AND COMPLETE AN AFFIDAVIT OF DIRECT PAYMENT IF YOU WISH TO REQUEST THAT THE COURT APPLY THE CREDIT TO THE OBLIGOR'S ARREARAGE. IF YOU DO NOT WISH TO APPLY THE CREDIT, PLEASE BE ADVISED THAT THE OBLIGOR MAY PROVE ELIGIBILITY FOR THE CREDIT THROUGH CANCELLED CHECKS, MONEY ORDERS AND/OR BANK DEPOSITS.

ENFORCEMENT OF HEALTH INSURANCE PREMIUMS AND/OR UNREIMBURSED MEDICAL BILLS NOT COVERED BY INSURANCE

You may be entitled to reimbursement of health care costs you have incurred on behalf of the children. This may be health insurance premiums and any health care cost incurred on behalf of the children but not covered by health insurance (co-pay, deductible, uncovered costs, etc.). Reimbursement of the cost of health insurance may be provided in your parent-child order. If your order requires Obligor to maintain health insurance, and s/he fails to do so, your order may require that s/he reimburses you the cost of health insurance. In that event, you are required to notify him/her in writing of the cost of insurance and make "demand" for payment.

If your order does not require reimbursement, but Obligor fails to provide health insurance as ordered, EPCDRO can request that the Court order reimbursement of the health insurance premium for each month the Obligor failed to provide health insurance. No notice is necessary in this type of case. In addition, Obligor can be ordered to pay 100% of uninsured medical expenses in this situation.

In both cases, please provide a letter from your employer/Human Resource Department reflecting the cost of health insurance and listing each person covered by your insurance coverage during the period for which you are seeking reimbursement.

ENFORCEMENT OF HEALTH INSURANCE PREMIUMS

Does the court order require the Obligor to maintain health insurance coverage for the named child(ren)?

_____YES _____NO

Does the Obligor currently maintain health insurance for the child(ren)?

_____YES _____NO

Did you purchase/obtain health insurance for the children (other than CHIP or Medicaid) because Obligor failed to maintain health insurance coverage? _____YES _____NO

Does the court order require the Obligor to reimburse you for health insurance premiums paid on behalf of the child(ren)?

_____YES _____NO

How much is the Obligor required to reimburse to you for health insurance premiums?

_____ALL _____ONE-HALF _____OTHER _____ NONE

Please specify time frame(s) during which you have paid for health insurance coverage for the children.

_____

_____

Please provide a letter from your employer/Human Resource Department, reflecting the cost of health insurance and listing each person covered by your insurance coverage. Be sure to list only the amount you pay for coverage for the subject child(ren). **DO NOT** include any amounts you pay for yourself or any other household member who is not a subject child of this suit. (You can calculate this by deducting the amount you would pay to insure yourself alone from the amount you pay to insure yourself and the child(ren).

If your court order requires that you notify Obligor of any change in health insurance premium cost, please provide a copy of the notice letter you sent to Obligor. ***IF YOU HAVE NOT PROVIDED THE REQUIRED NOTICE TO THE OTHER PARTY, PLEASE DO SO IMMEDIATELY USING THE ATTACHED LETTER FORMAT AND PROOF OF COVERAGE. IT SHOULD BE MAILED BY BOTH FIRST CLASS MAIL AND CERTIFIED MAIL; ASK THE POSTAL SERVICE EMPLOYEE TO STAMP YOUR COPY OF THE LETTER WITH THE DATE OF MAILING (POSTMARK) TO PROVE THAT THE LETTERS WERE MAILED. IF THE CERTIFIED LETTER IS RETURNED, PLEASE SUBMIT THE UNOPENED LETTER ALONG WITH THIS APPLICATION.***

UNINSURED MEDICAL EXPENSE REIMBURSEMENT INFORMATION
"OUT OF POCKET" MEDICAL EXPENSES

Most court orders require both parents to pay half of medical expenses paid on behalf of the children but not reimbursed by insurance. Most court orders also require the parent who incurs the expense to send a copy of the bill, receipt, etc. to the other parent within a certain time period. If notice is not given within that time period, the other parent may not be held in contempt for failure to timely reimburse the expense. However, the Court can still order that the other parent reimburse the uninsured portion of the medical expense. Before we can help you enforce this part of your court order, you MUST provide us with the following information with respect to EACH AND EVERY medical bill for which you seek reimbursement. You also MUST provide a copy of each receipt, bill, invoice, or other proof of the medical expense **and** proof that the payment was made by you. The receipt, bill, invoice, or other proof of expense must include the provider's name, date of service, patient name and date of payment.

Does the court order require the Obligor to reimburse medical expenses not covered by insurance but incurred on behalf of the child(ren)?

_____YES _____NO

What portion of uninsured medical expenses is the Obligor required to pay?

_____ALL _____ONE-HALF_____OTHER

EPCDRO will only seek enforcement of uninsured medical expenses incurred within the past twenty-four (24) months and submitted with this application. Once a motion to enforce has been filed with the Court, EPCDRO reserves the right to refuse to include additional medical expenses or newly incurred expenses within the pending action. Proper notice to the other parent is required.

PLEASE ATTACH A COPY OF EACH NOTICE LETTER, MEDICAL EXPENSE LOG AND EVERY BILL AND/OR RECEIPT THAT HAS BEEN SUBMITTED TO THE PARTY FROM WHOM REIMBURSEMENT IS DUE, ALONG WITH PROOF THAT THE INFORMATION WAS MAILED.

IF YOU HAVE NOT PROVIDED THE REQUIRED NOTICE TO THE OTHER PARTY, PLEASE DO SO IMMEDIATELY USING THE ATTACHED LETTER FORMAT AND MEDICAL EXPENSE LOG. IT SHOULD BE MAILED BY BOTH FIRST CLASS MAIL AND CERTIFIED MAIL; ASK THE POSTAL SERVICE EMPLOYEE TO STAMP YOUR COPY OF THE LETTER WITH THE DATE OF MAILING (POSTMARK) TO PROVE THAT THE LETTERS WERE MAILED. IF THE PERSON OWING THE EXPENSE FAILS TO REIMBURSE THE EXPENSES WITHIN THIRTY (30) DAYS OF THE DATE THE NOTICE WAS MAILED, YOU MAY SUBMIT THIS APPLICATION. IF THE CERTIFIED LETTER IS RETURNED, PLEASE SUBMIT THE UNOPENED LETTER ALONG WITH THIS APPLICATION.

NOTICE

THE ABOVE INFORMATION MUST BE SUBMITTED IN THE EXACT FORMAT REQUIRED. FURTHER, COPIES OF ALL INSURANCE PAYMENTS AND MEDICAL BILLS MUST ACCOMPANY YOUR APPLICATION.

FAILURE TO SUBMIT THE INFORMATION IN THE MANNER REQUESTED WILL CAUSE A DELAY IN PROCESSING YOUR CASE.

ADMONISHMENTS

THE EL PASO COUNTY **DOMESTIC RELATIONS OFFICE** ENFORCEMENT DIVISION REPRESENTS ONLY THE COURT THAT HAS RENDERED THE ORDER AS "FRIEND OF THE COURT". THE OFFICE REPRESENTS NEITHER THE APPLICANT NOR THE PAYOR. BOTH PARTIES HAVE THE RIGHT TO HIRE AN ATTORNEY TO REPRESENT THEM IN ANY COURT ACTION THAT MAY BE TAKEN BY THE **DOMESTIC RELATIONS OFFICE.**

THE EL PASO COUNTY **DOMESTIC RELATIONS OFFICE** ENFORCEMENT DIVISION IS LIMITED TO ENFORCEMENT OF THE CHILD SUPPORT ONLY, AND WILL NOT REPRESENT THE APPLICANT NOR ACCEPT SERVICE FOR THE APPLICANT IF ANY COUNTER MOTION IS FILED.

THE EL PASO COUNTY **DOMESTIC RELATIONS OFFICE** ENFORCEMENT DIVISION WILL NOT FILE AN ENFORCEMENT ACTION IF LITIGATION OF ANY KIND IS CURRENTLY PENDING IN YOUR CASE.

I SWEAR OR AFFIRM THAT I HAVE READ THE ENTIRE APPLICATION, I UNDERSTAND THE INFORMATION CONTAINED THEREIN AND THE INFORMATION I HAVE WRITTEN ON THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY BELIEF AND KNOWLEDGE, AND I AGREE WITH THE TERMS SET FORTH ABOVE.

_____
APPLICANT SIGNATURE

_____
DATE SIGNED

UNINSURED MEDICAL EXPENSES INCURRED BY _____

FOR THE PERIOD OF _____ TO _____

(PLEASE LIST THE PAYMENTS IN ORDER BY DATE, OLDEST TO MOST RECENT)

#	DATE OF BILL OR EXPENSE	SERVICE PROVIDER	NAME OF CHILD	AMT. NOT PAID BY INSURANCE, AMT. PAID BY OBLIGEE	AMOUNT OWED
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					

[DATE] _____

_____

_____

_____

Re: In the Interest of _____, Child(ren)
Cause No. _____

Dear _____:

As you are aware, the parent-child order requires that you reimburse me _____% of all uninsured medical expenses.

I am enclosing copies of uninsured medical expenses which I have paid during the period of _____ to _____. As you will see from the enclosed Medical Expense Log, your share of the expenses is $_____ and is due within _____ days of the date of this letter.

Please remit payment to me through the El Paso County Domestic Relations Office, 500 E. San Antonio, Rm LL-108, El Paso, Texas 79901, together with a copy of this letter.

Thank you for your cooperation in this matter.

Sincerely,

_____
Address _____
_____

[DATE]_____

_____

_____

_____

Re: In the Interest of _____, Child(ren)
Cause No. _____

Dear _____:

As you are aware, the parent-child order requires that you reimburse me for the cost of health insurance for the children.

I am enclosing a copy of the notice of health insurance coverage from my employer. Please note that the cost due is $_____ per month, beginning on the 1st day of next month.

Please remit payment to me through the Texas State Child Support Disbursement Unit, P.O. Box 659791, San Antonio, Texas, 76265-9791.

Thank you for your cooperation in this matter.

Sincerely,

_____
Address _____
_____