

**REQUEST TO PROTECT INFORMATION**  
Michigan Department of Health and Human Services

Name (print first, middle, last)			Date of Birth
Address Line 1 (where I live)		Address Line 2	
City		State	Zip Code
Docket Number		IV-D Case Number	

I fear for the safety of myself and/or my child(ren) due to past or possible future domestic violence or child abuse. I ask the child support program not to share the following information with other people on my case(s):

- Social Security number
- Address(es)
- Phone number(s)
- Driver's license number

I ask the child support program to send my mail to the alternate address below:

Address Line 1		Address Line 2	
City		State	Zip Code

By signing this document, I promise all information on this form is true and correct.

Signature	Date
-----------	------

After completing this form, you may:

- Fax it to the Office of Child Support Central Operations at 517-335-3030; or
- Deliver it to the local Prosecuting Attorney office or Friend of the Court office that is working on your case.

**\*\*This document contains confidential information, meant for a specific individual and purpose, and is protected by law. If you are not the intended recipient, you must destroy this document.\*\***

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.
--