OMB Control No.: 0970-XXXX
Expiration Date: XX/XX/XXXX

Central Authority Payment (CAP) Service State Contact Form

Information on this State Contact Form is required to enroll in the CAP Service. Please return the completed form to the CAP Administrator at CAP_Program@acf.hhs.gov.

The CAP Administrator will contact you to complete the enrollment process upon receipt of this form.

This form can also be used to update information previously provided to CAP. Check the appropriate box in the field when providing an update to existing information.

You must complete all fields. If not applicable, enter "N/A".

1. State Name: ____

2. Primary Contact Information:
   a. First Name: __________________ Last Name ______________ Middle Initial ____
   b. Direct Phone Number: ____
   c. Direct Email Address: ____

   Enter the primary contact's name (first name, last name, and middle initial), phone number, and email address. Please do not provide a general email address as this will be the primary means of communication used by CAP to contact your state if there is an issue with a payment.

   ☐ This is an update. Please replace existing information.

3. Secondary Contact Information:
   a. First Name: __________________ Last Name ______________ Middle Initial ____
   b. Direct Phone Number: ____
   c. Direct Email Address: ____

   Enter the secondary contact's name (first name, last name, and middle initial), phone number, and email address. This contact information will be used if CAP is unable to reach the primary contact.

   ☐ This is an update. Please replace existing information.

4. Alternate Contact Information:
   a. First Name: __________________ Last Name ______________ Middle Initial ____
   b. Direct Phone Number: ____
   c. Direct Email Address: ____

   Enter the alternate contact's name (first name, last name, and middle initial), phone number, and email address. This contact information is crucial if CAP is unable to reach the primary and secondary contacts.

   ☐ This is an update. Please replace existing information.

5. State Child Support Agency Mailing Address:
   a. Organization Name: ____
   b. Address Line 1: ____
   c. Address Line 2: ____
   d. C/O Address Line: ____
   e. State: ____
   f. Zip Code: ____

   Enter the name of your state's child support agency and the mailing address of your agency.

   ☐ This is an update. Please replace existing information.

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