



# Department of Public Health and Human Services

Public Health and Safety Division ♦ Financial Services & Operations Bureau

Office of Vital Records ♦ 111 N Sanders Rm 6 ♦ PO Box 4210 ♦ Helena, MT 59604-4210

Phone: (406) 444-2685 ♦ Fax: (406) 444-1803

**Steve Bullock, Governor**

**Sheila Hogan, Director**

Dear New Parent:

Congratulations on the birth of your new child.

A certificate of birth for every child born in Montana must be completed and filed within ten calendar days after the date of birth. 37.8.301 (1) Administrative Rules of Montana (ARM)

In order to place a birth certificate on file with the State of Montana, we require that the enclosed Homebirth worksheet be completed, and that **three** documents be provided to prove the following:

1. Proof of Pregnancy
2. Proof of residence in Montana at the time of birth or proof that the birth occurred in Montana.
3. Proof of Live birth

Within this packet you should have the following forms:

- Form A: Requirements for filing an Unattended Homebirth (4 pages)
- Form B: Homebirth Worksheet (2 pages)
- Form C: Paternity Acknowledgment
- Form D: Notice of Withdrawal of Paternity Acknowledgment
- Form E: Affidavit of Non-Paternity

Also included are instructions for filling out the certifier and attendant information, as well as the marital and paternity questions.

We have compiled this handout to assist you in obtaining the required documents to file your child's birth certificate.

Please do not contact your local Registrar! If at any time you have any questions, please contact the State of Montana Office of Vital Records at (406) 444-2685

These forms can also be printed from the following web site:

[www.dphhs.mt.gov/vitalrecords/vitalrecordsforms](http://www.dphhs.mt.gov/vitalrecords/vitalrecordsforms)

Please mail the completed original Home birth worksheet and original documents to:

Montana Vital Records

PO Box 4210

Helena, MT 59604

To contact DPHHS Director: PO Box 4210 ♦ Helena, MT 59604-4210 ♦ (406) 444-5622 ♦ [www.dphhs.mt.gov](http://www.dphhs.mt.gov)

## REQUIREMENTS FOR FILING AN UNATTENDED HOMEBIRTH

If a child is born at home, mother and/or father are responsible for filing the birth certificate, as stated in 50-15-221 (4), MCA. Please include evidence of the pregnancy, evidence that the infant was born alive, and evidence the birth occurred within this state. If the homebirth worksheet is received in our office after the child's first birthday, a delayed birth certificate must be filed.

**Please complete and sign the enclosed homebirth worksheet.**

Documentation to substantiate the facts of this birth is required to file a home birth. Documents used as proof of the fact of birth must be dated within 30 days of the date of birth and must establish the following:

1. One document must show: **Proof of pregnancy**
2. One document must show: **Proof of residence in Montana at the time of birth or proof that the birth occurred in Montana.**
3. One document must show: **Proof of Live Birth**

**The following may be submitted as proof of live birth:**

1. A copy of the medical record of the child if he or she was seen shortly after birth by any of the following: physician, registered nurse, nurse practitioner or public health nurse.
2. The laboratory results of the metabolic screening test (PKU). The blood sample must have been collected within ten days of the birth and forwarded to the laboratory within twenty-four hours following collection.
3. A notarized affidavit from the mother's employer confirming the dates of her pregnancy or the fact that she had a live baby recently.
4. A notarized affidavit by a public official that confirms the live birth of the child to this mother. The public official must have personal knowledge of the live birth.
5. Insurance policy that identifies the child's date and place of live birth.
6. The child's certified blessing or baptismal certificate. The blessing or baptismal certificate must either have a raised seal of the church or be accompanied by a notarized statement from the church minister or other church official.

**The following may be submitted as proof of pregnancy:**

1. Copy of mother's pregnancy lab tests
2. Copy of ultrasound
3. Copy of doctor record of pregnancy visits
4. A copy of the mother's prenatal or postnatal medical care record, signed by the person completing the record if not a hospital or clinic.  
These should have mother's name, date of service, name of lab, Hospital, or clinic.

**Form A (page 1 of 4)**

**Questions concerning this form? Please contact us at (406) 444-2685**

**The following documents (listing street address or rural route) may be submitted as proof of residence:**

1. Utility service or telephone statements at the time of the child's birth.
2. Bank statement at the time of the child's birth.
3. Social service records at the time of the child's birth if parent(s) or child were receiving public assistance (e.g. WIC, Food Stamps, Medicaid), or child support records
4. Mail- Personalized delivery through the U.S. Postal Service and cancelled by said agency. This must be postmarked at or near time of child's birth.
5. Rent or mortgage receipts at the time of the child's birth; a notarized statement from the landlord may also be required.

Note: Other documents may be accepted as proof of birth or proof of residence at the discretion of the State Registrar.

## **CERTIFIER INFORMATION/ATTENDANT INFORMATION ON HOMEBIRTH WORKSHEET**

### **CERTIFICATION STATEMENT AND SIGNATURE:**

A signature of the certifier is required. The Certifier is the person that was present during birth and can attest that the child was born alive at the place and time and date as stated. If only the mother was present at the delivery, the mother can sign as the certifier.

### **CERTIFIER - NAME & TITLE:**

Print the name and title of the person whose signature appears as certifier and specify the title of certifier: i.e., father, relative, owner of premises, etc.

These are legal items indicating that the facts of birth are correct. They add authenticity to the document and indicate who delivered the baby. The mailing address of the certifier is needed for possible questions concerning the birth.

### **DATE SIGNED (Month, Day, Year)**

Print the date the certifier signed the certificate.

### **ATTENDANT'S NAME, TITLE**

Print the name and title of the person that delivered the baby i.e., father, relative, owner of premises, etc.

**Was Mother Married at Conception, Birth or Anytime between?**

Yes       No

Check “YES” if you are married or were married at conception, birth or any time between. This would also include, if your child was born and you were married at the time of birth, or had been married to your husband within 10 months of the birth or 300 days of the birth. Continue to question “**Was Mother Married to the Father?**” Refer to Montana Code Annotated 40-6-105 (1)(A) MCA

Check “NO” if you are not married or were not married at conception, birth or any time between. Continue to question “**Will Father sign Paternity Acknowledgement?**” 50-15-221 (7)(b) MCA

**Was Mother Married to the Father?**

Yes       No

Check “YES” if married to the Father, print the name of your husband on the worksheet. Skip questions “**Will Husband sign Non-Paternity Affidavit?**” and “**Will Father sign Paternity Affidavit?**”

Check “NO” if not married to the Father. Continue to question “**Will Husband Sign Non-Paternity affidavit?**”

**Will Husband Sign Non-Paternity Affidavit?**

Yes       No

Check “YES”, both the mother and husband must fill out, sign and have notarized **Affidavit of Non-Paternity**. This form must be included with **Homebirth Worksheet**. Continue to “**Will Father Sign Paternity Affidavit?**” 50-15-221 (7)(a) (ii) (iii) MCA

Check “NO”, print husband’s name in the “Father’s” Information. Refer to 50-15-221 (7)(A) (i)(ii)(iii) MCA



# HOMEBIRTH WORKSHEET

Parent Contact Information--Phone: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

<b>CHILD'S NAME (First)</b>	<b>(Middle)</b>	<b>(Last and Suffix if applicable)</b>	<b>DATE OF BIRTH</b>	<b>SEX</b>
<b>FACILITY-NAME (If not institution, give street and number)</b>		<b>CITY OR LOCATION OF BIRTH</b>	<b>COUNTY OF BIRTH</b>	<b>TIME OF BIRTH</b>
<b>PLACE OF BIRTH:</b> Home birth: planned to deliver at home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (Specify) _____				
<b>I certify that this child was born alive at the place and Time and on the date stated</b> <b>Signature</b>		<b>DATE SIGNED</b>	<b>ATTENDANT'S NAME, TITLE and NPI</b> (If other than certifier) _____ NPI _____	
<b>CERTIFIER'S NAME AND TITLE</b>		<b>MAILING ADDRESS (Street Number or Rural Route Number, City or Town, State, Zip Code)</b>		
<b>MOTHER'S FULL MAIDEN NAME (First, Middle, Maiden Last Name)</b>		<b>BIRTHPLACE (State or Foreign County)</b>	<b>DATE OF BIRTH (Month, Day, Year)</b>	
Does Mother live on a Reservation: Yes/No _____ If yes list what reservation: _____				
<b>RESIDENCE - STATE</b>	<b>COUNTY</b>	<b>CITY OR TOWN, AND ZIP CODE</b>	<b>STREET AND NUMBER</b>	<b>INSIDE CITY LIMITS</b>
<b>FATHER'S CURRENT LEGAL NAME (First, Middle, Last)</b>		<b>BIRTHPLACE (State or Foreign County)</b>	<b>DATE OF BIRTH (Month, Day, Year)</b>	
Does Father live on a Reservation: Yes/No _____ If yes list what reservation: _____				
<b>I certify that the personal information provided on this certificate is correct to the best Of my knowledge and belief</b> <b>Signature of Parent or Other Informant</b>			<b>MOTHER'S MAILING ADDRESS</b> (If same as residence, enter Zip code Only)	
Permission is given to provide Social Security Administration with information from this certificate to obtain a Social Security card for this child? Yes / No _____ Signature of Parent: _____				
Consent to be notified of available health services? Yes/No _____ CONSENT OBTAINED for INCLUSION in the MONTANA IMMUNIZATION INFORMATION SYSTEM? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
	<b>Was Mother Married at Conception, Birth or Anytime between?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Was Mother Married to the Father?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Will Husband Sign Non-Paternity Affidavit?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Will Father sign Paternity Affidavit?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>MOTHER'S SOCIAL SECURITY NUMBER:</b>		<b>FATHER'S SOCIAL SECURITY NUMBER:</b>		
<b>INFORMATION HIGHLIGHTED IN YELLOW IS REQUIRED</b>				
<b>MOTHER'S EDUCATION (Specify only the highest diploma or degree received)</b> <input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> 9 <sup>th</sup> -12 <sup>th</sup> grade: No Diploma <input type="checkbox"/> High School graduate or GED completed <input type="checkbox"/> Some college but no Degree <input type="checkbox"/> Associates Degree (e.g. AA, AS) <input type="checkbox"/> Bachelor's Degree (e.g. BA, AB, BS) <input type="checkbox"/> Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA) <input type="checkbox"/> Doctorate (e.g. PhD, EdD) or Professional Degree (e.g. MD, DDS, DVM, LLB, JD)		<b>MOTHER OF HISPANIC ORIGIN? Check the box that best describes whether the mother is Spanish/Hispanic/Latino. Check the "No" box if the mother is not Spanish/Hispanic/Latino.</b> <input type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____		<b>MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)</b> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Samoan <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ <input type="checkbox"/> Other (Specify) _____
<b>FATHER'S EDUCATION (Specify only the highest diploma or degree received)</b> <input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> 9 <sup>th</sup> -12 <sup>th</sup> grade: No Diploma <input type="checkbox"/> High School graduate or GED completed <input type="checkbox"/> Some college but no Degree <input type="checkbox"/> Associates Degree (e.g. AA, AS) <input type="checkbox"/> Bachelor's Degree (e.g. BA, AB, BS) <input type="checkbox"/> Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA) <input type="checkbox"/> Doctorate (e.g. PhD, EdD) or Professional Degree (e.g. MD, DDS, DVM, LLB, JD)		<b>FATHER OF HISPANIC ORIGIN? Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the "No" box if the father is not Spanish/Hispanic/Latino.</b> <input type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____		<b>FATHER'S RACE (Check one or more races to indicate what the father considers himself to be)</b> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Samoan <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ <input type="checkbox"/> Other (Specify) _____
<b>PRINCIPAL OF PAYMENT FOR DELIVERY:</b> <input type="checkbox"/> Private insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Self-pay <input type="checkbox"/> Other (Specify) _____		<b>DATE OF LAST NORMAL MENSES BEGAN (Month, Day, Year)</b>		<b>DID MOTHER GET WIC FOOD DURING PREGNANCY?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

# HOME BIRTH WORKSHEET CONTINUED

NUMBER OF PREVIOUS LIVE BIRTHS <i>(Do not include this child)</i>		NUMBER OF OTHER PREGNANCY OUTCOMES <i>(Spontaneous &amp; induced losses or ectopic pregnancies)</i>		DATE OF FIRST PRENATAL CARE VISIT (mm,dd,yyyy) or <input type="checkbox"/> No prenatal care		DATE OF LAST PRENATAL CARE VISIT (mm,dd,yyyy)		TOTAL NUMBER OF PRENATAL VISITS- <i>(If none, enter "0")</i>		
Now Living Number ___ <input type="checkbox"/> None	Now Dead Number ___ <input type="checkbox"/> None	Other Outcomes Number ___ <input type="checkbox"/> None		BIRTH WEIGHT (grams preferred, specify Unit)		OBSTETRIC ESTIMATE OF GESTATION (Completed weeks)		PLURALITY—Single, Twin Triplet, etc. <i>(Specify)</i>		
DATE OF LAST LIVE BIRTH (mm,yyyy)		DATE OF LAST OTHER PREGNANCY OUTCOME (mm,yyyy)		IS INFANT BEING BREASTFED AT DISCHARGE? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF NOT SINGLE BIRTH—Born First, Second, Third, Etc. (Specify)		IS INFANT LIVING AT TIME OF REPORT <input type="checkbox"/> Yes <input type="checkbox"/> No		
APGAR SCORE			MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, enter name of facility transferred from:			INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY If yes, enter name of facility transferred to: <input type="checkbox"/> Yes <input type="checkbox"/> No				
5 Minute		10 Minutes								
CIGARETTE SMOKING BEFORE AND DURING PREGNANCY For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. IF NONE, ENTER "0".										
Average number of cigarettes or packs of cigarettes smoked per day.					Alcohol use during pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, average number of drinks per week _____					
MOTHER'S HEIGHT _____ (feet/inches)			MOTHER'S PREPREGNANCY WEIGHT _____ (pounds)			MOTHER'S WEIGHT AT DELIVERY _____ (pounds)				
HEP B VACCINATION INFORMATION – INFANT Hep B Birth Dose Given <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Parent Refused <input type="checkbox"/> Unknown HBsAg Test Date: (mm,dd,yyyy) _____					HEP B TESTING INFORMATION- MOTHER Hep B Administration Date: (mm,dd,yyyy) _____ Time: _____ am / pm HBsAg Test Result <input type="checkbox"/> Positive-Reactive <input type="checkbox"/> Negative-Nonreactive <input type="checkbox"/> Unknown					
CONSENT OBTAINED for INCLUSION in the MONTANA IMMUNIZATION INFORMATION SYSTEM? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown										
ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)					CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)					
<input type="checkbox"/> Assisted ventilation required immediately following delivery <input type="checkbox"/> Assisted ventilation required for more than six hours <input type="checkbox"/> NICU admission <input type="checkbox"/> Newborn given surfactant replacement therapy <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis <input type="checkbox"/> Seizure or serious neurologic dysfunction <input type="checkbox"/> Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention) <input type="checkbox"/> None of the above					<input type="checkbox"/> Anencephaly <input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Omphalocele <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes) <input type="checkbox"/> Cleft Lip with or without Cleft palate <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Hypospadias <input type="checkbox"/> Meningocele/Spina bifida <input type="checkbox"/> Congenital diaphragmatic hernia <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Cleft Palate alone <input type="checkbox"/> Suspected Chromosomal disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> None of the anomalies listed above					
MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)			OBSTETRIC PROCEDURES (Check all that apply)			METHOD OF DELIVERY				
Diabetes <input type="checkbox"/> Prepregnancy (Diagnosis prior to this pregnancy) <input type="checkbox"/> Gestational (Diagnosis during this pregnancy)  Hypertension <input type="checkbox"/> Prepregnancy (Chronic) <input type="checkbox"/> Gestational (PIH, Preeclampsia) <input type="checkbox"/> Eclampsia <input type="checkbox"/> Previous preterm birth <input type="checkbox"/> Other previous poor pregnancy outcome (Includes Perinatal death, small for gestational age, intrauterine growth restricted birth) <input type="checkbox"/> Pregnancy result from infertility treatment-if yes, check all that apply <input type="checkbox"/> Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination <input type="checkbox"/> Assisted reproductive technology (e.g., in vitro Fertilization (IVF), gamete intrafallopian transfer (GIFT)) <input type="checkbox"/> Mother had a previous cesarean delivery If yes, how many _____ <input type="checkbox"/> None of the above			<input type="checkbox"/> Cervical cerclage <input type="checkbox"/> Toclysis  External cephalic version: <input type="checkbox"/> Successful <input type="checkbox"/> Failed <input type="checkbox"/> None of the above			A. Was delivery with forceps attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No  B. Was delivery with vacuum extraction attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No  C. Fetal presentation at birth <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other  D. Final route and method of delivery (Check one) <input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean  If cesarean, was a trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No				
INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)			CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)			MATERNAL MORBIDITY (Check all that apply) (Complications associated with labor and delivery)				
<input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Chlamydia <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> None of the above			<input type="checkbox"/> Induction of labor <input type="checkbox"/> Augmentation of labor <input type="checkbox"/> Non-vertex presentation <input type="checkbox"/> Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery <input type="checkbox"/> Antibiotics received by the mother during labor <input type="checkbox"/> Clinical chorioamnionitis diagnosed during labor or maternal temperature $\geq 38^{\circ}\text{C}$ (100.4°F) <input type="checkbox"/> Moderate/heavy Meconium staining of the amniotic fluid <input type="checkbox"/> Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery <input type="checkbox"/> Epidural or spinal anesthesia during labor <input type="checkbox"/> None of the above			<input type="checkbox"/> Maternal transfusion <input type="checkbox"/> Third or fourth degree perineal laceration <input type="checkbox"/> Ruptured uterus <input type="checkbox"/> Unplanned hysterectomy <input type="checkbox"/> Admission to intensive care unit <input type="checkbox"/> Unplanned operative room procedure following delivery <input type="checkbox"/> None of these above				



**MONTANA DEPARTMENT OF  
PUBLIC HEALTH & HUMAN SERVICES  
VITAL RECORDS & STATISTICS BUREAU  
PO BOX 4210  
HELENA, MT 59604-4210**

**PATERNITY  
ACKNOWLEDGMENT**

**PLEASE PRINT HARD USING A BALL POINT PEN**

CHILD'S NAME ( <i>First, Middle, Last</i> )	DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY OF BIRTH	HOMEBIRTH ADDRESS	
MOTHER'S NAME ( <i>First, Middle, Last (MAIDEN SURNAME)</i> )		MOTHER'S DATE OF BIRTH
MOTHER'S STATE OF BIRTH ( <i>If Not U.S.A. Give Country</i> )	MOTHER'S RACE	MOTHER'S SOCIAL SECURITY NUMBER
FATHER'S NAME ( <i>First, Middle, Last</i> )	FATHER'S RACE	FATHER'S DATE OF BIRTH
FATHER'S ANCESTRY	Education (Elementary/Secondary) (0-12) College (1-4 or 5+)	FATHER'S SOCIAL SECURITY NUMBER
FATHER'S STATE OF BIRTH ( <i>If Not U.S.A. Give Country</i> )	FATHER'S OCCUPATION	FATHER'S PLACE OF EMPLOYMENT

**BOTH PARENTS MUST SIGN BEFORE A NOTARY PUBLIC**

We the natural mother and father, declare under penalty of perjury under the laws of the State of Montana that the following statements are true and correct. When completed and filed with the state registrar this Voluntary Declaration of Paternity establishes a father-child relationship identical to the relationship established when a child is born to married parents. **NOTICE TO BOTH PARENTS: THIS IS A LEGALLY BINDING DOCUMENT.** Upon signing this declaration, it becomes your duty under law to provide support and care for the child as the parent. **Do not sign** this declaration if you do not understand the legal effect of the document or you have doubts about the paternity of the child. **If you wish to withdraw this Acknowledgement, you must do so within 60 days, or before a support or paternity order for the child is entered, whichever is earlier.**

**PLEASE PRINT/SIGN HARD USING A BALL POINT PEN**

<p>I certify that I am the natural mother. The above information is true and the man named above is the only possible father. I make this affidavit to name the natural father on my child's birth certificate. I understand the rights, responsibilities, alternatives, and consequences of signing this affidavit.</p> <p><b><u>Verification of Signer's ID is Mandatory</u></b></p> <p>Mother's Signature _____          Address _____          City, State, Zip _____</p> <p>State of _____          County of _____</p> <p>This document was signed and sworn to (or affirmed) before me          on _____ by _____          (Date) (Name of Signer)</p> <p>_____          (Notary's Signature)</p> <p>[Official Stamp]</p>	<p>I certify that the above information is true. I make this affidavit to show that I am the natural father on my child's birth certificate. I also understand that by acknowledging paternity of this child, I accept an obligation to provide child support under the laws of the State of Montana. I understand the rights, responsibilities, alternatives, and consequences of signing this affidavit.</p> <p><b><u>Verification of Signer's ID is Mandatory</u></b></p> <p>Father's Signature _____          Address _____          City, State, Zip _____          Phone Number _____</p> <p>State of _____          County of _____</p> <p>This document was signed and sworn to (or affirmed) before me          on _____ by _____          (Date) (Name of Signer)</p> <p>_____          (Notary's Signature)</p> <p>[Official Stamp]</p>
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**Fill this out ONLY if Mother or Father wish to withdraw the signed**

**Paternity Acknowledgement within 60 days from the date you signed the Paternity Acknowledgment, or before a support or paternity order for the child is entered, whichever is earlier.**

STATE OF MONTANA  
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES  
OFFICE OF VITAL RECORDS

**NOTICE OF WITHDRAWAL OF PATERNITY ACKNOWLEDGMENT**

I, \_\_\_\_\_, signed an acknowledgment of paternity  
(Your name)  
for \_\_\_\_\_ on \_\_\_\_\_.  
(Child's name) (Date paternity acknowledgment was signed)

A copy of this notice of withdrawal was provided to me with the paternity acknowledgment form. Having reconsidered my action signing the acknowledgment, I hereby withdraw, cancel and rescind my acknowledgment.

I understand that this withdrawal is useless and of no effect unless it is filed with the Montana Department of Public Health and Human Services within **60 days** of the date the paternity acknowledgment was signed, or before a support or paternity order for the child is entered, whichever is earlier. I understand that to file this document, I must present it in person to the department at the address below, or mail it to the department at the mailing address below so that it is received and available for filing with the department's vital records before the withdrawal period ends.

I further certify that I have provided a copy of this notice to the other party who signed the acknowledgment of paternity.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Verification of Signer's ID is Mandatory**

State of: \_\_\_\_\_

County of: \_\_\_\_\_

This Document was signed and sworn to (or affirmed) before me on \_\_\_\_\_

By \_\_\_\_\_  
(Name of Signer)

(Date)

\_\_\_\_\_  
(Notary Signature)

[Official Stamp]

**INSTRUCTIONS FOR FILING THIS WITHDRAWAL NOTICE**

You may file this document:

**IN PERSON:**

DPHHS  
Office of Vital Records  
111 Sanders St., Rm 6  
Helena, MT 59620

**BY MAIL:**

DPHHS  
Office of Vital Records  
PO Box 4210  
Helena, MT 59604-4210

**AFFIDAVIT OF NONPATERNITY**

I \_\_\_\_\_, being duly sworn, deposes and says that: I was married to  
Husband's Name

\_\_\_\_\_ on \_\_\_\_\_ in \_\_\_\_\_, State  
Wife's Name Date of Marriage City

My wife gave birth to a \_\_\_\_\_ child in \_\_\_\_\_ on  
Sex City County

\_\_\_\_\_. The name of the child is \_\_\_\_\_  
Date of Birth Child's Name

I now state that although legally married at the time of this birth, I am not the father of the  
named child. I request that my name not be listed on the birth certificate.

\_\_\_\_\_  
Husband's Signature

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State and Zip Code

**Verification of Signer's ID is Mandatory**

State of: \_\_\_\_\_  
County of: \_\_\_\_\_

\_\_\_\_\_ Personally appeared before me and whose identity I proved on the  
basis of satisfactory evidence to be the signer of the above instrument.

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

=====

I, \_\_\_\_\_, am the mother of \_\_\_\_\_ and I state that  
Mother's Name Child's Name

I was legally married at the time of the birth. My husband as listed is not the father of the above  
named child and I request that his name not be listed on the birth certificate.

\_\_\_\_\_  
Wife's Signature (Mother)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State and Zip Code

**Verification of Signer's ID is Mandatory**

State of: \_\_\_\_\_  
County of: \_\_\_\_\_

This document was signed and sworn  
to (or affirmed) before me on \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
(Notary's Signature)

[Official Stamp]