



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. If a child is born outside of a birthing facility such as a home, vehicle, etc. without a licensed midwife present, the parents are responsible for filing the birth certificate. If a home birth worksheet is not received by our office within the first year of the child's life, a delayed birth certificate must be filed instead. Please refer to our website at <https://dphhs.mt.gov/vitalrecords/HomeBirths> for more information.

The cost to file a birth record for a baby is \$25. Please include a check or money order made out to Montana Vital Records with the completed paperwork. If you have any questions, please contact Melody Lee with the State of Montana Office of Vital Records at (406) 444-0693.

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

- Proof of pregnancy
- Proof of residence in Montana at the time of birth or proof the birth occurred in Montana.
- Proof of live birth

Within this packet you have the following forms. Not all are required for every situation:

- Accepted Documents and Helpful Information
- Home birth worksheet (2 pages)
- Paternity Acknowledgment and Notice of Withdrawal of Paternity Acknowledgment
- Affidavit of non-paternity
- Birth Certificate Application

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

<https://dphhs.mt.gov/vitalrecords/HomeBirths>

A birth certificate is not automatically issued once this process is completed. If you would like to order a certified copy of your child's birth certificate, please complete the included Birth Certificate Application and provide payment of \$16 per certificate.

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

Montana Vital Records
PO Box 4210
Helena, MT 59601



Home Birth Packet

Accepted Documents and Helpful Information

The following may be submitted as proof of live birth:

- 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.
- 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.
- A notarized affidavit from the mother's employer confirming the dates of her pregnancy or the fact that she had a live baby recently.
- 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.
- Insurance policy that identifies the child's date and place of live birth.
- 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:

- Copy of mother's pregnancy lab tests.
- Copy of ultrasound.
- Copy of record of pregnancy visits.
- Copy of the mother's prenatal or postnatal medical care records, signed by the person completing the record if not a hospital or clinic.
- NOTE: all copies should have mother's name, date of service, and name of facility.

The following documents may be submitted as proof of residence. These documents must list street address or rural route:

- Utility service or telephone statements at the time of the child's birth.
- Bank statement at the time of the child's birth.
- Social service records at the time of the child's birth if the parent(s) or child were receiving public assistance such as WIC, food stamps, Medicaid, or child support records.
- Mail with personalized delivery through the United States Postal Service and cancelled by said agency. The mail must be postmarked at or near the time of the child's birth.
- Rent or mortgage receipts at the time of the child's birth or a notarized

statement from the landlord may also be required.

Helpful Definitions:

1. Certifier Signature:
 - a. The certifier is the person that was present during the birth and can attest that the child was born alive at the place, time, and date stated. If only the mother was present at the delivery, the mother can sign as the certifier.
 - b. The certifier must provide a printed date, name, title, and signature on the provided Home Birth Worksheet. The title of the certifier can be described as father, mother, relative, owner of premises, etc.
 - c. Certifier's mailing address must be provided on the Home Birth Worksheet for possible questions concerning the birth.
2. Attendant Signature:
 - a. The attendant is the person who delivered the baby. This could be the father, relative, midwife, etc.
 - b. They provide signature and title on the provided Home Birth Worksheet.
3. Paternity Acknowledgement:
 - a. This document is completed when the mother is not married to the natural father at the time of birth or conception and the natural father would like to be listed on the birth certificate.
4. Paternity Withdrawal
 - a. This document can be completed if the person who claims paternity no longer wants to be listed as the father on the birth certificate. This must be completed within 60 days of the original signature on the paternity acknowledgement.
5. Affidavit of Non-Paternity:
 - a. This document should be completed if the mother was married at the time of birth to someone other than the biological father and the husband does not want to be listed as the child's father on the birth certificate. If the mother was not married at the time of birth, this does not need to be completed. If the mother was married to who should be listed as the father on the birth certificate, this does not need to be completed.

Helpful Questions and Information Regarding Paternity:

This does not need to be sent back to OVR, it is just a tool to assist you in determining which paternity forms (if any) need to be completed.

1. Was the mother married at conception, birth, or anytime in between?

YES

NO

If yes, move to question 2.

If no, move to question 3.

2. Was mother married to the father?

YES

NO

If yes, write the name of your spouse on the Home Birth Worksheet. Skip questions 3 and 4 and do not complete the Paternity Acknowledgement or Affidavit of Non-Paternity. No further action needs to be taken.

If no, continue to question 3.

3. Will husband be listed on the birth certificate as the child's father?

YES

NO

If yes, print the name of the husband as the child's father on the Home Birth Worksheet.

If no, both the mother and the husband must complete an Affidavit of Non-Paternity. They must fill it out, sign it, and have it notarized. This document must be returned to the Office of Vital Records with the Home Birth Worksheet to have the husband not listed as the child's father.

Continue to question 4.

4. Will the biological father be listed on the child's birth certificate?

YES

NO

If yes, a Paternity Acknowledgement must be completed by both the parents. They must fill it out, sign it, and have it notarized. Then fill out the biological father's name on the Home Birth Worksheet. Return the Paternity Acknowledgement with the Home Birth Worksheet to have the father listed on the child's birth certificate.

If no, do not print the father's information on the Home Birth Worksheet.

HOME BIRTH WORKSHEET

Parent Contact Information -Phone: _____

Email Address: _____

CHILD'S NAME (First)	(Middle)	(Last and Suffix if applicable)	DATE OF BIRTH	SEX
FACILITY-NAME (If not institution, give street and number)		CITY OR LOCATION OF BIRTH	COUNTY OF BIRTH	TIME OF BIRTH
PLACE OF BIRTH: Home birth: planned to deliver at home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (Specify) _____				
I certify that this child was born alive at the place and Time and on the date stated Signature		DATE SIGNED	ATTENDANT'S NAME, TITLE and NPI (If other than certifier) NPI	
CERTIFIER'S NAME AND TITLE		MAILING ADDRESS (Street Number or Rural Route Number, City or Town, State, Zip Code)		
MOTHER'S FULL MAIDEN NAME (First, Middle, Maiden Last Name)		BIRTHPLACE (State or Foreign County)	DATE OF BIRTH (Month, Day, Year)	
Does Mother live on a Reservation: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes list what reservation: _____				
RESIDENCE – STATE	COUNTY	CITY OR TOWN, AND ZIP CODE	STREET AND NUMBER	INSIDE CITY LIMITS
FATHER'S CURRENT LEGAL NAME (First, Middle, Last)		BIRTHPLACE (State or Foreign County)	DATE OF BIRTH (Month, Day, Year)	
Does Father live on a Reservation: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes list what reservation: _____				
I certify that the personal information provided on this certificate is correct to the best Of my knowledge and belief Signature of Parent or Other Informant			MOTHER'S MAILING ADDRESS (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? <input type="checkbox"/> Yes <input type="checkbox"/> No Signature of Parent: _____				
Consent to be notified of available health services? <input type="checkbox"/> Yes <input type="checkbox"/> No CONSENT OBTAINED for INCLUSION in the MONTANA IMMUNIZATION INFORMATION SYSTEM? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
MOTHER'S EDUCATION (Specify only the highest diploma or degree received) <input type="checkbox"/> 8 th grade or less <input type="checkbox"/> 9 th -12 th 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)		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. <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) _____		MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be) <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) _____
FATHER'S EDUCATION (Specify only the highest diploma or degree received) <input type="checkbox"/> 8 th grade or less <input type="checkbox"/> 9 th -12 th 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)		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. <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) _____		FATHER'S RACE (Check one or more races to indicate what the father considers himself to be) <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) _____
Was Mother Ever Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Was Mother Married at Conception, Birth or Anytime between? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was Mother Married to the Father? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will Husband Sign Non-Paternity Affidavit? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will Father sign Paternity Affidavit? <input type="checkbox"/> Yes <input type="checkbox"/> No
MOTHER'S SOCIAL SECURITY NUMBER:		FATHER'S SOCIAL SECURITY NUMBER:		
PRINCIPAL OF PAYMENT FOR DELIVERY: <input type="checkbox"/> Private insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Self-pay <input type="checkbox"/> Other (Specify) _____		DATE OF LAST NORMAL MENSES BEGAN (Month, Day, Year)		DID MOTHER GET WIC FOOD DURING PREGNANCY? <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 & 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 <i>(grams preferred, specify Unit)</i>		OBSTETRIC ESTIMATE OF GESTATION <i>(Completed weeks)</i>		PLURALITY—Single, Twin Triplet, etc. <i>(Specify)</i>	
DATE OF LAST LIVE BIRTH <i>(mm,yyyy)</i>		DATE OF LAST OTHER PREGNANCY OUTCOME <i>(mm,yyyy)</i>		IS INFANT BEING BREASTFED AT DISCHARGE? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF NOT SINGLE BIRTH—Born First, Second, Third, Etc. <i>(Specify)</i>		IS INFANT LIVING AT TIME OF REPORT <input type="checkbox"/> Yes <input type="checkbox"/> No	
APGAR SCORE 5 Minute 10 Minutes			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			
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. # of cigarettes # of packs Three Months Before Pregnancy _____ OR _____ First Three Months of Pregnancy _____ OR _____ Second Three Months of Pregnancy _____ OR _____ Third Trimester of Pregnancy _____ OR _____			Alcohol use during pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, average number of drinks per week _____			
MOTHER'S HEIGHT _____ <i>(feet/inches)</i>		MOTHER'S PREPREGNANCY WEIGHT _____ <i>(pounds)</i>			MOTHER'S WEIGHT AT DELIVERY _____ <i>(pounds)</i>				
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) <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					CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply) <input type="checkbox"/> Anencephaly <input type="checkbox"/> Meningomyelocele/Spina bifida <input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Congenital diaphragmatic hernia <input type="checkbox"/> Omphalocele <input type="checkbox"/> Gastroschisis <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"/> Cleft Palate alone <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Suspected Chromosomal disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Hypospadias <input type="checkbox"/> None of the anomalies listed above				
MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply) 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			OBSTETRIC PROCEDURES (Check all that apply) <input type="checkbox"/> Cervical cerclage <input type="checkbox"/> Tocolysis External cephalic version: <input type="checkbox"/> Successful <input type="checkbox"/> Failed <input type="checkbox"/> None of the above ONSET OF LABOR (Check all that apply) <input type="checkbox"/> Premature Rupture of the Membranes (prolonged, ≥12 hrs.) <input type="checkbox"/> Precipitous Labor (<3 hrs.) <input type="checkbox"/> Prolonged Labor (≥20 hrs.) <input type="checkbox"/> None of the above			METHOD OF DELIVERY 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) <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			CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply) <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 ≥ 38°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			MATERNAL MORBIDITY (Check all that apply) (Complications associated with labor and delivery) <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			



STATE OF MONTANA

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
PATERNITY ACKNOWLEDGMENT

There is no charge for the processing of this form within the first year of birth. Please note that there is a \$41.00 processing fee after the first year of birth, payable to Montana Vital Records (via check, cashier's check, or money order). This fee covers one certified copy of the amended birth certificate to be sent upon completion. Also, please include a photocopy of either parent's current valid state ID with their current mailing address and phone number noted. Please send fee, ID, and original notarized form to: Montana Vital Records: PO Box 4210, Helena MT 59604-4210

Form with fields for CHILD'S NAME, DATE OF BIRTH, SOCIAL SECURITY NUMBER, CITY OF BIRTH, HOSPITAL, MOTHER'S NAME, MAIDEN SURNAME, MOTHER'S DATE OF BIRTH, MOTHER'S STATE OF BIRTH, MOTHER'S RACE, SOCIAL SECURITY NUMBER, FATHER'S NAME, FATHER'S RACE, FATHER'S DATE OF BIRTH, FATHER'S ANCESTRY, EDUCATION, SOCIAL SECURITY NUMBER, FATHER'S STATE OF BIRTH, 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 statement are true and correct. When completed and filed with the state registrar this Paternity Acknowledgment 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 acknowledgment, it becomes your duty under law to provide support and care for the child as the parent. Do not sign this acknowledgment 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 acknowledgment, 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 USING A BALLPOINT PEN

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.

Mother's Signature
Address
City, State, Zip

Verification of Signer's ID is Mandatory

State of
County of
This document was signed and worn to (or affirmed) before me on (Date) by (Name of Signer)

(Notary's Signature)
[Official Stamp]

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

Father's Signature
Address
City, State, Zip

Verification of Signer's ID is Mandatory

State of
County of
This document was signed and worn to (or affirmed) before me on (Date) by (Name of Signer)

(Notary's Signature)
[Official Stamp]



STATE OF MONTANA

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 for
(Your name)

_____ 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 _____ (Date)
(Name of Signer)

(Notary Signature)

[Official Stamp]

INSTRUCTIONS FOR FILING THIS WITHDRAWAL NOTICE

You may file this document either in person or by mail.

In person at:

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

Mail to:

Office of Vital Records
PO Box 4210
Helena, MT 59604

MONTANA VITAL RECORDS
111 N SANDERS RM 6 / PO BOX 4210
HELENA, MONTANA 59604-4210
Phone: 406-444-2685

PLEASE READ THESE INSTRUCTIONS CAREFULLY

WHO CAN ORDER A BIRTH CERTIFICATE?

Only those authorized by 50-15-121 MCA and 37.8.126 ARM, which includes the registrant (14 years old or older), the registrant's spouse, children (with proof of relationship), parents, grandparents (with proof of relationship), a caretaker relative, guardian, an authorized representative, or those who provide documentation showing it is needed for determination or protection of the individuals personal or property rights. Proof of relationship, guardianship, caretaker relative, or authorization is required to obtain a certified copy of a birth record.

Step-relatives, in-laws, aunts, uncles, cousins, ex-spouses, and a natural parent of an adoptive child are not eligible to receive a certified copy of a birth certificate.

IDENTIFICATION IS REQUIRED

The person signing the request must provide an enlarged legible photocopy of both sides of their valid driver's license or other legal picture identification with a signature or the requestor must have this application notarized.

Suggested Identification

Picture ID with a Signature	OR Two Forms of ID – One MUST have a Signature	OR
<ul style="list-style-type: none"> • Driver's License • State ID Card • Passport • Military ID Card • Tribal 	<ul style="list-style-type: none"> • Social Security Card • Work ID Card • Car registration/Insurance • Doctor/Medical record • Fishing License • US Military DD214 • Utility Bill with a current address • Voter Registration Card 	<ul style="list-style-type: none"> • Credit/Debit/ATM Card • School ID Card • Insurance Record • Pay Stub • Traffic/ Pawn ticket • Court record
		<ul style="list-style-type: none"> • Have an authorized family member that has an ID order the certificate

If a picture ID with a signature is not available, two other forms of identification are required; one **MUST** have a signature. Please include photocopies of **both sides** of the ID when mailing your request. **IMPORTANT: If the identification requirement is NOT met or if the application is incomplete, your request will be returned and significant delays in processing your order may occur.**

FEE (All fees must be U.S. funds)

- **CERTIFIED COPIES OF A BIRTH CERTIFICATE: Effective September 21, 2024** cost \$16.00 each (**non-refundable**)
- **INFORMATIONAL COPIES OF A BIRTH CERTIFICATE** may be issued to anyone as long as the birth occurred 30 years prior to the date of application, the cost is \$16.00. (**non-refundable**)
- **CERTIFIED COPIES OF DOCUMENTS** on file with the state (i.e. Acknowledgment of Paternity, correction affidavits), **the cost is \$16.00 (non-refundable)**
- **SEARCHES:** \$10.00 for the first 5 years searched, then \$1.00 per year over the first five years per name requested. (An informational copy will be issued if record is found) (**non-refundable**)

Please Make CHECKS Payable To: MONTANA VITAL RECORDS

Please complete the following information.

FULL First, Middle and Last Name on Birth Certificate: _____

Has name ever been changed other than marriage No Yes If so, original name: _____

Date of Birth: _____ Place of Birth (City or County): _____ Sex of Child: _____

Mother's **Full Maiden** Name: _____

Father's Full Name: _____

Your relationship to the certificate holder: _____ (*self, mother, father etc.*) _____ # of copies needed

Reason Birth Certificate is needed: _____

Mailing or Delivery Address:

Name: _____

Address: _____ City, State, Zip: _____

Daytime Telephone Number: _____ Signature of Applicant: _____

Email Address: _____

Notary (For use if needed) Verification of Signer's ID Is Mandatory

State of _____
 County of _____

This record was signed and sworn to (or affirmed) before me on _____ by _____
 (Date)

 (Name of Applicant)

 (Notary's Signature)

[Official Stamp]

Official Use Only
Date _____
Rec# _____
Amount _____
Cert # _____
Ser # _____
Comment _____

NOTICE: STATE LAW PROVIDES PENALTIES FOR PERSONS WHO WILLFULLY AND KNOWINGLY USE OR ATTEMPT TO USE THIS CERTIFICATE FOR ANY PURPOSE OF DECEPTION. (50-15-114, MCA)