

IN THE CIRCUIT COURT OF THE STATE OF OREGON

FOR THE COUNTY OF _____

Family Law Department

In the Matter of the Marriage of:

_____,

and

_____,

Petitioner,

Respondent,

Case No. _____

UNIFORM SUPPORT
AFFIDAVIT OF _____

Child\Spousal Support Case

This form is a **SWORN AFFIDAVIT** (under oath) required for child support determinations. It must be signed before a notary public, may be made available to the other party, and may be filed in court. The form consists of this part, on pages 1 and 2, and Schedule 1--Income, Deductions and Medical/Dental Insurance and Schedule 2 Monthly Expenses and Rebutting Factors, **BOTH OF WHICH ARE REQUIRED**. In addition, certain documentation MUST be attached as indicated on Page 2.

STATE OF OREGON, County of Washington) ss.

I, _____, being duly sworn under oath, depose and say that I am the _____ in the above entitled matter and that the following is true to the best of my knowledge and belief:

1. Your Age: _____
Date of Birth _____
Social Security Number: _____

2. Residence Address _____
City _____ State _____ Zipcode _____

3. Name of Employer _____
Address _____
City _____ State _____ Zipcode _____

4. Occupation _____

5. Length of Employment _____

6. Children born or adopted during THIS relationship:

<u>Name of Child</u>	<u>Age</u>	<u>Living With:</u>		
_____		Me	Other Parent	Other
_____		Me	Other Parent	Other
_____		Me	Other Parent	Other
_____		Me	Other Parent	Other

7. List all people LIVING IN YOUR HOUSEHOLD
(other than children named in item 6 above)

<u>Name</u>	<u>Relationship to You</u>	<u>Age</u>	<u>Monthly Income</u>

8. List your other dependents or children NOT LISTED IN ITEMS 6 OR 7 ABOVE:

<u>Name</u>	<u>Age</u>	<u>Relationship to You</u>	<u>Monthly Income</u>

9. ENTER THE FOLLOWING INFORMATION FROM SCHEDULES INDICATED:

A. TOTAL GROSS INCOME
(from page 6, Item 16D) _____

B. TOTAL EXPENSES OF CHILDREN _____
(from Schedule 1, Item 1)

C. TOTAL MONTHLY EXPENSES _____
(from Schedule 1, Item 6)

10. (a) Are you or your present spouse entitled to receive court ordered child support for any children now living with you? If "Yes", complete the following and ATTACH A COPY OF ALL SUCH CHILD SUPPORT ORDERS Yes No

<u>Name of Child</u>	<u>Age</u>	<u>Relationship to You</u>	<u>Support Amount</u>
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(b) Are those support payments being made? Yes No

11. Are you required to pay a court-ordered child support obligation for a child of yours who is not listed in item 6 above? If "Yes", complete the following and ATTACH A COPY OF ALL SUCH CHILD SUPPORT ORDERS. Yes No

<u>Name of Child</u>	<u>Age</u>	<u>Name of Recipient</u>	<u>Support Amount</u>
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12. Are you ordered to pay or entitled to receive court-ordered spousal support? If "Yes", complete the following and ATTACH A COPY OF ALL SUCH SPOUSAL SUPPORT ORDERS. Yes No

<u>Owed To</u>	<u>Paid By</u>	<u>Monthly Amount</u>
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Owed Until: _____

13. Are you incurring child care costs on behalf of the children listed in Item 6 above? If "Yes", complete the following and attach documentation verifying the information provided below: Yes No

<u>Name of Child</u>	<u>Name and Address of Daycare Provider</u>	<u>Monthly Cost*</u>
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* gross amount paid before application of any tax credit of subsidy

14. Do you receive any subsidy for such care? Yes No

If so, amount per month: _____

15. MEDICAL AND DENTAL ELECTIONS--The child support recipient may elect to require the support payor to name the child(ren) as the beneficiary(ies) on a health/dental insurance plan. If so elected, the child support may be adjusted by an amount equal to all or a portion of the cost to parent who provides the child(ren)'s portion of the health/dental insurance premium.

PLEASE CHOOSE:

I wish to require health/dental insurance coverage by the other party and understand that a portion of the premium may be deducted from support.

I do not wish to require health/dental insurance coverage by the other party.

I provide health/dental insurance through my employer; see Item 18 of this schedule for information.

ATTACHMENT CHECKLIST:

Required

Last four (4) payroll stubs.

Most recent federal and state income tax return.

Copies of any and all relevant child/spousal support orders.

Optional

Child care documentation if you want this considered.

Medical/dental insurance documentation.

INCOME, DEDUCTIONS AND MEDICAL/DENTAL INSURANCE

You must complete and submit the following attachments: copies of recent: (1) federal and state income tax returns, (2) last four pay stubs, and (3) if self-employed, most recent profit and loss statement.

16. YOUR MONTHLY GROSS INCOME

A. From Employment: If paid weekly, multiply weekly income by 4.3 to arrive at a monthly gross income and insert below. If paid every two weeks, multiply two weeks' income by 2.15 and insert below:

Gross Hourly Wage: _____

Average Number of Hours Worked Per Week: _____

<u>Description</u>	<u>Monthly Amount</u>
Gross Monthly Income	_____
Gross Monthly Tips, Commissions or Bonuses	_____
<u>Subtotal 16 (a) :</u> _____	

B. From Self-Employment: If you own an interest in a partnership or in a closely held corporation, attach last year's Schedule K-1, and/or corporation federal income tax return.

	<u>Monthly Amount:</u>
Gross Receipts	_____
Expense Reimbursements:	_____
Rental Income:	_____
Royalty Income:	_____
Less Ordinary/Necessary Expenses:	_____
Plus Monthly Portion of Accelerated Component of any Depreciation Allowance or Investment Tax Credits:	_____
<u>Subtotal 16 (b) :</u> _____	

C. Other Sources of Income: (Please attach verification of any income available to you as listed below):

Monthly Amount:

Dividends _____
Interest Income _____
Trust Income _____
Contract Payments Less Underlying Debt _____
Annuity Income _____
Pension/IRA/Keogh (Non-Social Security) _____
Social Security Income _____
Worker's Compensation Benefits
(weekly amount multiplied by 4.3) _____
Unemployment Benefits
(weekly amount multiplied by 4.3) _____
Disability Income _____
Gifts or Prizes _____
Spousal Support _____
Expense Reimbursements and/or Per
Diem not listed in Item B above _____
ADC Benefits _____
FCAS (Food Stamps) _____
Other _____

Please Specify: _____

Subtotal 16 (c): _____

D. Summary of your Gross Income

Income from Employment (item 16 (a) above) _____

Self-Employment Income (item 16 (b) above) _____

Other Income (item 16 (c) above) _____

YOUR TOTAL MONTHLY GROSS INCOME:

**Enter Here and on the Uniform
Support Affidavit, Page 2 16 (d):** _____

17. Your Monthly Deductions from Gross Income:

A. Mandatory Deductions:

Number of exemptions _____
claimed by you

Monthly Cost

State Income Taxes _____

Federal Income Taxes _____

Social Security (FICA) _____

Worker's Compensation _____

Wage Withholding/Garnishment _____ -----Paid to: _____

Medical Insurance for the
Parties' Joint Children, if
Additional Premium: _____

(Total premium, less the cost
of coverage for yourself and
other dependents

Subtotal of Mandatory 17 (a) : _____

B. Optional Deductions

Monthly Cost

Retirement/Profit Sharing _____

Savings Plan _____

Credit Union _____

Other _____ -----Specify _____

Subtotal of Optional 17 (b) : _____

C. Summary of Deductions

Mandatory (from Item 17 (a) above: _____

Optional (from Item 17 (b) above: _____

TOTAL MONTHLY DEDUCTIONS 17 (c) : _____

18. Information for Medical and Dental Insurance Coverage:

(Coverage for children listed on page 1, item 6, of this schedule which is presently provided or available for the benefit of these children.):

I provide this (complete information below)

Other parent provides this (complete if known)

Health Insurance:

Name of Insurance Company _____

Plan or Group Name _____

Plan/Group Number _____

Individual ID Number _____

Address for Claims Submission _____

Phone Number for Information _____

Amount of Annual Deductible _____

Gross Monthly Premium Paid by You _____
(exclude amounts paid by employer)

Monthly Premium to Cover You _____

Dependent's Portion of
Monthly Premium _____

Are there dependents other than children on page 1,
item 6, of this schedule enrolled with health plan? Yes No

If "Yes", total number of other dependents: _____

Dental Insurance:

Name of Insurance Company _____

Plan or Group Name _____

Plan/Group Number _____

Individual ID Number _____

Address for Claims Submission _____

Phone Number for Information _____

Amount of Annual Deductible _____

Gross Monthly Premium Paid by You _____
(exclude amounts paid by employer)

Monthly Premium to Cover You _____

Dependent's Portion of
Monthly Premium _____

Are there dependents other than children on page 1,
item 6, of this schedule enrolled with health plan? Yes No

If "Yes", total number of other dependents: _____

I certify that my answers and the information on this affidavit and the attached schedules are true to the best of my knowledge and ability. I further certify that the information on the attached documents is true to the best of my knowledge and ability.

DATED this _____ day of _____, 2003

Signature

SCHEDULE 1
(MONTHLY EXPENSES AND REBUTTING FACTORS)

You MUST complete this schedule; however, this schedule is to be considered only if either party intends to rebut the presumptive child support order. These are the total household expenses you must pay each month. Utility bills should be averaged over the year. Any other annual, quarterly, or other periodic payments should be converted to a monthly average.

DO NOT LIST ANY EXPENSE IF IT IS DEDUCTED FROM YOUR WAGES.
ONLY INCLUDE DIRECT EXPENSES FOR JOINT CHILDREN IN SECTION 1.

1. Direct monthly expenses for children of this relationship which you pay:

School Lunches _____

Books, Tuition _____

Activities _____

Other _____ -----Specify: _____

B. Food (other than school lunches) _____

C. Daycare _____

D. Clothing _____

E. Medical Insurance _____

F. Unreimbursed Health Costs _____

G. Unreimbursed Dental Costs _____

H. Babysitting (not work related) _____

I. Lessons _____

J. Grooming Needs _____

K. Hobbies, Recreation _____

L. Entertainment _____

M. Allowances _____

N. Transportation _____

O. Miscellaneous _____ -----Specify: _____

Total Direct Expenses paid
Children (add 1 (a) through 1 (o)) _____

Enter HERE and on the Uniform Support Affidavit Page 2 line 9 (b)

Average Monthly Amount of Child's Income:

Name _____

Amount _____

Source _____

2. Fixed Costs

A. Residence

Mortgage or Rent _____

Property Taxes
(if not included in mortgage) _____

Second Mortgage _____

Other _____ ---Specify _____

B. Utilities

Electricity _____

Heat (other than electricity) _____

Water _____

Garbage _____

Telephone _____

Other _____ ---Specify _____

C. Transportation

Car Payments _____

Gas and Oil _____

Maintenance and Repairs _____

Other _____ ---Specify _____

D. Insurance

Life _____

Automobile _____

Medical/Dental _____

Residence _____

E. Food and Household Items

(exclude food expenses for children covered in Schedule 1, Item 1 above)

F. Clothing

Clothing _____

Grooming/Personal Needs _____

G. Medicine and Pharmaceutical

(unreimbursed medical/dental costs) _____

H. Court/DHR Ordered Support Payments _____

TOTAL FIXED COSTS (add 2 (a) through 2(h) : _____

3. Consumer Obligations

Name of Creditor _____

Name of Creditor _____

Balance Due _____

Balance Due _____

Monthly Payment _____

Monthly Payment _____

**TOTAL MONTHLY PAYMENTS
ON CONSUMER OBLIGATIONS** _____

4. Discretionary Expenses

A. Entertainment _____

B. Vacations _____

C. Gifts _____

D. Religious Contributions _____

E. Dues and Subscriptions _____

F. Club Memberships and Dues _____

TOTAL DISCRETIONARY EXPENSES _____

5. Additional Expenses

Expense _____

Expense _____

Total Owing _____

Total Owing _____

Monthly Payment _____

Monthly Payment _____

TOTAL ADDITIONAL EXPENSES _____

6. TOTAL EXPENSES EXCLUDING DIRECT EXPENSES OF CHILD
(add Items 2,3,4,5 and 6): _____

ENTER HERE AND ON PAGE 2, LINE 9 OF USA

Other factors that affect my income and expenses or that should be considered to rebut the presumptive child support calculations (attach supporting documentation whenever possible):