

IN THE CIRCUIT COURT OF THE STATE OF OREGON

FOR THE COUNTY OF _____

In the Matter of the Marriage of _____)
) Case No. _____)
 ,)
)
 and _____ Petitioner,) UNIFORM SUPPORT AFFIDAVIT
) OF PETITIONER/RESPONDENT (CHILD/
) SPOUSAL SUPPORT CASE)
 ,)
)
 Respondent.)

This form is an AFFIDAVIT (under penalty of perjury) required for support determinations. It must be signed, filed with the court, and served upon the other party (or their attorney). If no party seeks spousal support or a deviation (change) from the uniform child support guidelines, you need only complete the Affidavit (pages 1 - 5) and provide any attachments requested on those pages. If any party seeks either spousal support or any deviation (change) from the uniform child support guidelines, you must complete not only the Affidavit (pages 1 - 5) and provide any attachments requested on those pages, but also Schedule 1 - Monthly Expenses and Rebutting Factors. In addition, certain documentation MUST be attached as indicated on page 3.

STATE OF OREGON)
) ss.
 County of)

I, _____, being first duly sworn upon oath, depose and say that I am the petitioner/respondent in the above-entitled matter and that the following are true to the best of my knowledge and belief:

1. Your Age: _____ DOB: _____ Social Security Number: Filed pursuant to UTCR 2.100
2. Residence Address: _____
3. Name of Employer & Address: _____
4. Occupation: _____ Title: _____
5. Length of employment: _____
6. Children born of or adopted during THIS relationship:

Name of Child:	Age:	Child living with: (Me, other parent, other)
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Name:	Age:	Relationship to you:	Monthly Income:
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

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

Name:	Age:	Relationship to you:	Monthly Income:
_____	_____	_____	\$ _____

9. ENTER THE FOLLOWING INFORMATION FROM SCHEDULES INDICATED:

- A. TOTAL GROSS INCOME (From page 3, item 16.D) \$ _____
- 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? YES ___ NO ___ If "YES," complete the following and ATTACH A COPY OF ALL SUCH CHILD SUPPORT ORDERS.

Name of Child:	Age:	Relationship to you:	Monthly Support Amount:
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

(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 #6 above? YES ___ NO ___ If "YES", complete the following and ATTACH A COPY OF ALL SUCH CHILD SUPPORT ORDERS.

Name of Child:	Age:	Name of Recipient:	Monthly Support Amount:
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

12. Are you ordered to pay or entitled to receive court-ordered SPOUSAL support? YES ___ NO ___ If "YES", complete the following and ATTACH A COPY OF ALL SUCH SPOUSAL SUPPORT ORDERS

<u>Owed to:</u>	<u>Paid by:</u>	<u>Monthly Support Amount:</u>
_____	_____	_____
<u>Owed Until: _____ (Date or Event): _____</u>		

13. Are you incurring child care costs on behalf of the children listed in #6 above? YES ___ NO ___ If "YES," complete the following and ATTACH DOCUMENTATION verifying the information provided below:

Name of Child:	Day-care Provider and Address:	Monthly Cost (gross amount before tax credit/subsidy):
_____	_____	\$ _____
_____	_____	\$ _____

14. Do you receive any subsidy for such care? If so, amount: \$ _____ per mo.

15. MEDICAL & DENTAL ELECTIONS - The child support recipient may elect to require the support payor to name the child(ren) as the beneficiary 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. Choose one:

- ___ 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 page 5, item #18 for information.

REQUIRED ATTACHMENTS

OPTIONAL ATTACHMENTS

- ___ Last four (4) payroll stubs
- ___ Most recent federal and state income tax returns
- ___ Copies of any and all relevant child/spousal support orders

- ___ 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 (4) pay stubs, and (3) if self-employed, most recent Profit & 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 2 weeks' income by 2.15 and insert below:

<u>Description</u>	<u>Monthly Amount</u>
Gross Hourly Wage: \$_____	
Average Number of hours worked per week:_____	
Gross Monthly Income:	\$ _____
Gross Monthly tips/commissions/bonuses (identify):\$_____	\$ _____

SUBTOTAL: 16.A. \$ _____

- 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 corporate federal income tax return:

<u>Description</u>	<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:	\$ _____

SUBTOTAL: 16.B. \$ _____

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

<u>Description</u>	<u>Monthly Amount</u>
Dividends:	\$ _____
Interest Income:	\$ _____
Trust Income:	\$ _____
Contract Payments (less underlying debt):	\$ _____
Annuity Income:	\$ _____
Retirement Benefits - Pension/IRA/Keogh (non-social security):	\$ _____
Social Security Income:	\$ _____
Workers Compensation benefits per week x 4.3 =	\$ _____
Unemployment benefits per week x 4.3 =	\$ _____
Disability Income:	\$ _____

Gift or Prizes: \$ _____
 Spousal Support: \$ _____
 Expense Reimbursements and/or per diem allowance
 (not listed in Item B. above): \$ _____
 ADC Benefits: \$ _____
 FCAS (food stamps): \$ _____
 Other (Specify): _____ \$ _____

SUBTOTAL: 16.C. \$ _____

D. Summary of Your Gross Income:

<u>Description</u>	<u>Monthly Amount</u>
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 this
 Affidavit Page 2, line 9-A \$ _____

17. Your Monthly Deductions from Gross Income:

A. Mandatory Deductions:

Number of Exemptions claimed by you: _____

<u>Description</u>	<u>Monthly Amount</u>
State Income Taxes:	\$ _____
Federal Income Taxes:	\$ _____
Social Security (FICA):	\$ _____
Workers Compensation Insurance Premium:	\$ _____
Wage Withholding, Wage Assignment or Garnishment: (Paid to: _____)	\$ _____
Medical insurance for the parties' joint children if additional premium Total premium \$ _____ - less cost of coverage for yourself + other dependents =	\$ _____

SUBTOTAL OF MANDATORY: 17.A. \$ _____

B. Optional Deductions:

<u>Description</u>	<u>Monthly Amount</u>
Retirement/Profit Sharing:	\$ _____
Savings Plan:	\$ _____
Credit Union:	\$ _____
Other:	\$ _____

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 (For children listed on page 1, item 6, of this Affidavit which is currently provided or available for the benefit of those children):

I provide this
 Other parent provides this (complete if known)

	Health Insurance	Dental Insurance
Name of Insurance Company:	_____	_____
Plan or Group Name:	_____	_____
Plan/Group Number:	_____	_____
Individual I.D. Number:	_____	_____
Address for Claims Submission:	_____	_____
Phone Number for Information:	_____	_____
Amount of Annual Deductible:	_____	_____
Gross Monthly Premium Actually Paid by You (exclude amounts paid by your employer):	\$ _____	\$ _____
Monthly premium to cover only you:	\$ _____	\$ _____
Dependent's Portion of Monthly Premium:	\$ _____	\$ _____

Are there dependents other than children on Page 1, item 6, of this Affidavit enrolled with plan?

YES NO If Yes, total number of other dependents: _____

I hereby declare that the above statement and the attached schedules are true to the best of my knowledge and belief, and that I understand it is made for use as evidence in court and is subject to penalty for perjury.

DATED this _____ day of _____, 2007.

_____, Petitioner/Respondent

SCHEDULE 1

(Monthly Expenses and Rebutting Factors)

You MUST complete this schedule and prepare and submit the attachments requested in this schedule if either party seeks spousal support or any change from the uniform child support guidelines. 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:

		<u>Monthly Amount</u>
A.	School Expenses:	
	School Lunches:	\$ _____
	Books, Tuition:	\$ _____
	Activities:	\$ _____
	Other (Specify):_____	\$ _____
B.	Food (other than school lunches):.....	\$ _____
C.	Day Care:	\$ _____
D.	Clothing:	\$ _____
E.	Medical Insurance - Premium Payments:.....	\$ _____
F.	Unreimbursed Health Costs:	\$ _____
G.	Unreimbursed Dental Costs:	\$ _____
H.	Baby-Sitting (not work related):.....	\$ _____
I.	Lessons:	\$ _____
J.	Grooming Needs:	\$ _____
K.	Hobbies, Recreation:.....	\$ _____
L.	Entertainment:	\$ _____
M.	Allowances:	\$ _____
N.	Transportation:	
	Gasoline, Oil:	\$ _____
	Insurance for driving age child:.....	\$ _____
O.	Miscellaneous (Specify):_____	\$ _____

TOTAL DIRECT EXPENSES OF CHILDREN:
 (add 1.A THRU 1.O) ENTER HERE and on Uniform Support
 Affidavit page 2, line 9.B. 1. \$ _____

	<u>Source</u>	<u>Amount</u>	<u>Name</u>
Average Monthly Amount of Child's Income:	_____	\$ _____	_____

2.	FIXED COSTS	<u>MONTHLY AMOUNT</u>
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 & Oil:	\$ _____
	Maintenance & Repairs:	\$ _____
	Other (specify): _____	\$ _____
D.	INSURANCE:	
	Life:	\$ _____
	Automobile:	\$ _____
	Medical/Dental:	\$ _____
	Residence:	\$ _____
E.	FOOD & HOUSEHOLD ITEMS:	\$ _____
	(exclude food expenses for joint children covered in Schedule 1, part 1, above)	
F.	CLOTHING:	\$ _____
	Grooming/personal needs:.....	\$ _____
G.	MEDICINE/PHARMACEUTICAL:	
	Unreimbursed medical/dental costs:.....	\$ _____
H.	COURT/DCS ORDERED SUPPORT PAYMENTS:	\$ _____
	TOTAL FIXED COSTS: (add 2.A. thru 2.H) 2.	\$ _____

3. CONSUMER OBLIGATIONS:

<u>NAME OF CREDITOR</u>	<u>BALANCE DUE</u>	<u>MONTHLY PAYMENTS</u>
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
TOTAL MONTHLY PAYMENTS ON CONSUMER OBLIGATIONS: 3.		\$ _____

4.	DISCRETIONARY EXPENSES:		<u>MONTHLY AMOUNT</u>
	A. Entertainment:	\$ _____
	B. Vacations:	\$ _____
	C. Gifts:	\$ _____
	D. Religious Contributions:	\$ _____
	E. Dues and Subscriptions:	\$ _____
	F. Club Memberships & Dues:	\$ _____
	TOTAL DISCRETIONARY EXPENSES:	4.	\$ _____
5.	ADDITIONAL EXPENSES:		\$ _____
	_____		\$ _____
	_____		\$ _____
	TOTAL ADDITIONAL EXPENSES:	5.	\$ _____
6.	TOTAL EXPENSES EXCLUDING DIRECT EXPENSES OF CHILD: (add 2, 3, 4, and 5) ENTER HERE and on Uniform Support Affidavit Page 2, line 9.C.	6.	\$ _____
7.	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):		