Steven A. Heinrich, OSB No. 943376
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IN THE CIRCUIT COURT OF THE STATE OF OREGON

FOR THE COUNTY OF _____

In the Matter of the Marriage of PETITIONER, Petitioner, and RESPONDENT, Respondent.	No. _____ PETITIONER/RESPONDENT'S UNIFORM SUPPORT DECLARATION OR CSP Case No._____

SUMMARY INFORMATION - COMPLETE THIS PAGE LAST

After completing Sections 1 through 5, beginning on Page 2 below, insert the information and/or total MONTHLY amounts in this Summary Information Section.

Date of Completion _____ mm/dd/year

1. Number of Joint Children From This Relationship: _____
2. Number of Joint Children Over 18 But Under 21 Attending School: _____
3. Number of Non-joint Additional Children: _____
4. Gross Monthly Income From All Sources: $_____
5. Receiving Temporary Assistance for Needy Families? ☐ **Yes** ☐ **No**
6. Child(ren) on Oregon Health Plan/Health Kids or Other Public Health Plan? ☐ **Yes** ☐ **No**
7. Social Security or Veteran's Benefits Received for Child(ren): Person with Disability is: ☐ Child ☐ Me ☐ Other Parent $_____
8. Spousal Support RECEIVED by You: $_____
9. Spousal Support PAID by You: $_____

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10. Mandatory Union Dues Paid $_____

11. Health Care Premiums for Yourself Only if You Provide Insurance for Child(ren): $_____

12. Health Care Premiums Paid for Joint Child(ren): $_____

13. Out-of-Pocket Medical Expenses Paid for Joint Child(ren): $_____

14. Number of ANNUAL Overnights Child(ren) Spends with You: $_____

15. Childcare Expenses Paid for Joint Child(ren): $_____

16. City Where Childcare is Provided: _____

This form is a DECLARATION under penalty of perjury required for support determinations. It must be completed in its entirety, signed, filed with the court or appropriate administrative agency, and served upon the other party (or their attorney).

INSTRUCTIONS: Answer all questions. *Items marked with an * should be transferred to the Summary Information Section, above.* If you are seeking spousal support, you need to complete Schedule 1. Attach additional pages if necessary.

IMPORTANT: This information will be disclosed to the other party and may be subject to public access. Protections are available using the court's "Confidential Information Form" process.

1. **CHILDREN**

A. *List all JOINT CHILDREN (children under the age of 21 born or adopted during this relationship):

Name of Child	Age	Child Living With			Over 18 & Under 21 Attending School	
		Me	Other Parent	Other	Yes	No

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B. *List all NONJOINT ADDITIONAL CHILDREN (children under the age of 21 born or adopted by you but not of this relationship).

Name	Age

2. **YOUR GROSS INCOME**

A. From Your Employment:

Description				**Monthly Amount**
1	Gross hourly wage			
2	Average number of hours worked per pay period	**X**		
3	Convert to annual. If paid monthly, enter "12". If paid twice monthly, enter "24". Every two weeks, enter "26". Every week, enter "52".	**X**		
4	Convert to monthly	**X**		
5	Gross monthly income: 1. x 2. X 3. ÷ 4.	**÷**	12	
6	Gross monthly tips/commissions/bonuses (identify):			
Subtotal of Monthly Income from Employment (5) + 6)			**SUBTOTAL : 2.A.**	

B. Other Sources of Your Monthly Income: (Attach verification of your gross monthly income as listed below):

Description	**Monthly Amount**
Self-Employment	

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Dividends	
Interest Income	
Trust Income	
Annuity Income	
Social Security Income	
Workers' Compensation Benefits per week multiplied by 52; divided by 12	
Unemployment Benefits per week multiplied by 52; divided by 12	
Disability Income	
Expense Reimbursements and/or Per Dien Allowance not listed in item A. above	
Other (specify source/type):	
Other (specify source/type):	
SUBTOTAL: 2.B	
***Total of 2A + 2B Enter Here and on Page 1, #4** **TOTAL:**	

C. *Do you receive Temporary Assistance for Need Families?

☐ Yes, $_____ monthly

☐ No

D. *Do you receive Social Security or Veteran's benefits for <u>any joint child(ren)</u> due to <u>parent's</u> disability?

Name of Beneficiary Child(ren) _____ ☐ Yes, $_____monthly

☐ No

Name of Disabled Parent _____ Source: _____

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E. *Do you receive Social Security or Veteran's benefits for any joint child(ren) due to child's disability?

☐ Yes, $_____ monthly

☐ No

Name of Child(ren)_____ Source: _____

F. *Is there an order for you to RECEIVE spousal support from your spouse involved in this proceeding?

☐ Yes, $_____ monthly

☐ No

G. *Is there an order for you RECEIVE spousal support from a former/subsequent spouse?

☐ Yes, $_____ monthly

☐ No

H. *Are you ordered to PAY spousal support?

☐ Yes, $_____ monthly

☐ No

If Yes, to whom? _____

I. *Do you pay mandatory union dues?

☐ Yes, $_____ monthly

☐ No

J. ATTACH A COPY OF YOUR FOUR MOST RECENT PAY STUB(S), BENEFIT STATEMENTS, **AND** COPIES OF YOUR MOST RECENTLY FILED STATE AND FEDERAL TAX RETURNS.

ATTACH COPIES OF SPOUSAL SUPPORT ORDERS AND ANY CHILD SUPPORT ORDERS FOR NONJOINT CHILD(REN) NOT LIVING WITH YOU.

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3. **HEALTH CARE COVERAGE AND MEDICAL EXPENSES**

A. *Is there a cost to insure just yourself if you provide insurance for the child(ren)?

☐ **Yes**

☐ **No**

B. Do you provide health care coverage for your joint children?

☐ **Yes**

☐ **No**

C. Does someone else provide health care coverage for your joint child(ren)?

☐ **Yes**

☐ **No**

Name of person, or entity, providing, if other than you: _____

D. Are you or any member of your household:

i. Enrolled in the Oregon Health Plan, Healthy Kids, or any other public health care coverage?

☐ **Yes**

☐ **No**

ii. Receiving a state subsidy for public or private health care coverage?

☐ **Yes**

☐ **No**

E. Are any of the joint children enrolled in public health care coverage (Healthy Kids/Oregon Health Plan)?

Name of child(ren) enrolled? _____ ☐ **Yes**

☐ **No**

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If you answered "YES" to A, B, C, D, or E above:

i. Name **all** persons covered:_____

Relationship to you:_____

ii. What is the source of the insurance? (such as through your employer, spouse, other):_____

iii. Insurance Co.: _____

iv. Monthly amount of any state subsidy received by your household for public or private health-care coverage $_____.

v. Policy Number: _____

Group Number: _____

vi. Address for submission of claims: _____

vii. Your total monthly premium costs: (A) $_____; Cost to cover only you: (B) *$_____; Total number of people enrolled(not counting yourself):C_____; Number of joint children enrolled: (D)_____.

* The cost for the joint child(ren) only is (A-B) ÷C = $_____ x D = *$_____

viii. ATTACH PROOF OF INSURANCE PREMIUMS.

F. *Do you pay any <u>out-of-pocket</u> medical expenses (not covered by insurance) for any joint child(ren) on a monthly basis?

☐ **Yes**

☐ **No**

If yes, list the name of the child, the reason for the cost(s), and the amount <u>per month</u>:

i. _____; $

ii. _____; $

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iii. _____; $

iv. _____; $

G. Does anyone pay a share of a monthly out-of-pocket medical costs for the child(ren)?

☐ **Yes**

☐ **No**

If yes, who? _____; amount they pay? $_____

H. ATTACH PROOF OF MONTHLY MEDICAL EXPENSES.

4. **YOUR CHILDCARE EXPENSES**

A. *Do you pay for childcare for the joint child(ren) so you can work, train, or look for work?

☐ **Yes**

☐ **No**

If yes,:

Paid to:	**Name of Child**	**Age**	**Average Monthly Payment**

B. *Does anyone else share the cost of childcare for the joint child(ren)?

☐ **Yes**

☐ **No**

If yes, name:_____ **Average Monthly Amount:** $_____.

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C. *City where childcare is provided:_____

D. ATTACH COPY OF MOST RECENT PARENTING PLAN OR WRITTEN AGREEMENT.

5. **<u>*YOUR PARENTING TIME</u>**

☐ PROPOSED ☐ OCCURRING ☐ EXISTING PLAN OR WRITTEN AGREEMENT

A. How many ANNUAL overnights does each joint child spend with YOU?

i. Name of Child:_____ # of overnights:____

ii. Name of Child:_____ # of overnights:____

iii. Name of Child:_____ # of overnights:____

iv. Name of Child:_____ # of overnights:____

B. ATTACH COPY OF MOST RECENT PARENTING PLAN OR WRITTEN AGREEMENT.

4. **<u>YOUR REBUTTAL FACTORS</u>**

A. The amount of child support to be paid may be rebutted under OAR 137-050-0760 http://www.dcs.state.or.us/oregon_admin)rules/default.htm

i. Are you seeking a rebuttal (an adjustment to the support amount)?

☐ **Yes**

☐ **No**

ii. Explain briefly: _____

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B. ATTACH SUPPORTING EVIDENCE/ADDITIONAL INFORMATION.

I HEREBY DECLARE THAT THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND THAT I UNDERSTAND THEY ARE MADE FOR USE AS EVIDENCE IN COURT AND ARE SUBJECT TO PENALTY FOR PERJURY.

DATED this _____ day of _____, 20___.

My (printed) Name Is: _____

I am:

☐ PETITIONER ☐ RESPONDENT ☐ CO-PETITIONER

☐OTHER: _____

_____

SIGNATURE

ATTACHMENT CHECKLIST. Check the box and include the appropriate attachment(s).

☐ Four most recent pay stubs or benefit statements

☐ Most recent state and federal tax returns (including all applicable schedules)

☐ Proof of insurance premiums

☐ Proof of medical costs

☐ Most recent parenting plan or written agreement

☐ Proof of childcare costs

☐ Copies of Spousal and Child Support Orders

☐ Additional Page: Number items to correspond

☐ Other:_____

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CERTIFICATE OF MAILING

I hereby certify that I served a true and complete copy of this Uniform Support Declaration and all attachments by mailing it first class mail, with postage prepaid, on _____ (date) to the following people:

Attorney for _____

Dated this _____ .

_____
Steven A. Heinrich OSB# 943376
Attorney for _____ .

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Schedule 1

Spousal/Registered Domestic Partner Support Factors

You must complete this schedule and prepare and submit the attachments requested in this schedule if either party seeks spousal support. These are the total household expenses you must pay each month for yourself only and not for others in your household. 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.

1. **FIXED COSTS:**

Description	Monthly Amount
A. RESIDENCE	
Mortgage or Rent	
Second Mortgage/Home Equity Loan	
Property Taxes (if not included in Mortgage)	
Insurance	
B. UTILITIES	
Electricity	
Gas	
Garbage	
Telephone	
Cable/Internet	
C. TRANSPORTATION	
Car Payments	
Fuel	
Maintenance and Repairs	
Other (specify):	
D. INSURANCE:	

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Life	
Automobile	
Medical/Dental	
Other	
E. Food and Household Items	
F. Medicine & Pharmaceutical - unreimbursed medical/dental costs	
G. Court/DHR Ordered Support Payments for other than child(ren)/spouse/RDP in this case	
Total Fixed Costs (A-G):	

2. **CONSUMER OBLIGATIONS**:

Name of Creditor		**Balance Due**	**Monthly Amount**
A.			
B.			
C.			
D.			
E.			
F.			
TOTAL PAYMENTS ON CONSUMER OBLIGATIONS (A-F)			

3. **SUMMARY OF EXPENSES**:

Description	**Monthly Amount**
Fixed Costs (item 1 above)	
Consumer Obligations (item 2 above)	
TOTAL EXPENSES:	

4. **OTHER FACTORS:**

Other factors that affect my income and expenses or that should be considered (attach

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supporting documentation whenever possible).

_____

_____

_____

_____

_____

_____

_____

TOTAL:	

My (printed) Name Is: _____

I am:

☐ PETITIONER ☐ RESPONDENT ☐ CO-PETITIONER

☐OTHER: _____

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