

UNIFORM SUPPORT DECLARATION

IN THE CIRCUIT COURT OF THE STATE OF OREGON

FOR THE COUNTY OF CLACKAMAS

) Case Number:
)
 Petitioner,)
)
 and) UNIFORM SUPPORT DECLARATION OF
) Petitioner
) Respondent
)
 Respondent.)

SUMMARY INFORMATION - COMPLETE QUESTIONS 1, 2, 3, 5, 6, 7 & 11

(If I am doing this for you, my program will automatically fill this portion in except questions 1, 2, 3, 5, 6, 7, & 11)

	Date Completed	
1		Number of Joint Children from this relationship:
2		Number of Joint children over the 18 but under 21 attending school:
3		Number of your nonjoint children:
4		GROSS MONTHLY INCOME FROM ALL SOURCES
		\$ -
		TOTAL MONTHLY EXPENSES:
		\$ -
5		Receiving Temporary Assistance for Needy Families?
		____ Yes ____ No
6		Child(ren) on Oregon Health Plan/Healthy Kids or Other Public Plan?
		____ Yes ____ No
7		Amount of 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:
		\$ -
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):
		#REF!
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 Childcares is Provided
		0

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1. CHILDREN

JOINT CHILD(REN) OF THIS RELATIONSHIP

Over 18 & Under 21 Attending School

Name of Child	Age	Me	Other Parent	Other	YES	NO

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

Name	Age

TOTAL NUMBER OF NONJOINT CHILDREN

List all people living in your household or any party you claim as a dependent. Do not list children listed above.

NAME	Age	Relationship to You	Monthly Income

2. YOUR GROSS INCOME

A. From Your Employment

DESCRIPTION	AMOUNT
1 Gross hourly wage <input style="width: 100px;" type="text"/>	
2 Average number of hours worked in pay period: <input style="width: 150px;" type="text"/>	
3 Convert to annual. If paid monthly, enter "12". If paid twice monthly, enter "24". Every two weeks, enter "26". Every week, enter "52". →	
4 Convert to Monthly. (1*2 *3) Divided by 12	/12
5 Monthly Salary →	\$ -
6 Gross Monthly tips/commissions/bonuses	
SUBTOTAL OF MONTHLY INCOME FROM EMPLOYMENT	\$ -

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

DESCRIPTION OF INCOME	MONTHLY AMOUNT
Self-Employment:	
Dividends:	
Interest Income:	
Trust Income:	
Annuity Income:	
Retirement Benefits Pensions/IRA/Keogh (nonsocial security):	
Social Security	
Workers' Compensation Benefits Per Week Multiplied by 4.3 =	
Unemployment Benefits Per Week Multiplied by 4.3 =	
Disability Income:	
Expense Reimbursement and/or Per Diem Allowance not listed in item A. above	
Other:	
Other:	
SUBTOTAL:	\$ -

TOTAL MONTHLY INCOME FROM ALL SOURCES \$ -

Do you receive Temporary Assistance for Needy Families ? If Yes, Amount

Do you receive Social Security or Veteran's benefits for any joint children due to parent's disability?

Name of beneficiary child(ren) _____

Name of Disabled Parent: _____

Source: _____

Amount

Do you receive Social Security or Veteran's benefits for any joint children due to child's disability?

Name of Child _____

Amount

Is there an order for you to RECEIVE spousal support from your spouse involve in this proceeding?

Amount

Is there an order for you to RECEIVE spousal support from a former spouse?

Amount

Are you order to PAY spousal support? Amount

Do you pay mandatory union dues, if yes . . . Amount

ATTACH A COPY OF YOUR FOUR (4) 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 ADDITIONAL CHILDREN NOT LIVING WITH YOU.

3. HEALTH CARE COVERAGE AND MEDICAL EXPENSES

A Is there a cost to insure just yourself if you provide insurance for the children?

Yes No

B Do you provide health care coverage for your children?

Yes No

C Does someone else provide health care coverage for your joint children

Yes No

Name the Person or entity: Petitioner

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 a public health care coverage:

Yes No

If you answered **yes** to any of the questions:

Name all persons covered: _____

Source of the Insurance? (Work, spouse, other) _____

Insurance Co: _____ Telephone Number: _____

Monthly amount of any state subsidy received by your household for public or private health-care coverage:

Policy Number: Group Number:

Address for Submission of claims: _____

Your Total monthly premium Costs Total:

Total Cost to cover only you:

Total number of people enrolled: Don't Count yourself

Number of joint children enrolled:

Total Cost of joint children only is

Do you pay any out-of-pocket medical expenses (Not covered by Insurance) for nonjoint children on a monthly basis

Yes _____ No _____

If Yes, List the name(s) of the child and the reason for the cost(s) and the amount per month:

Name of child	Reason for the cost	Monthly Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Does anyone pay a share of the monthly out-of pocket medical cost for the children? _____

If Yes, Who _____ Amount they Pay

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4. YOUR CHILDCARE EXPENSES:

A. Do you pay for childcare for the joint children so you can work, train or look for work? Yes ____ No ____

If Yes:

Paid To:	Name of Child	AGE	Average Monthly Amount

B. Does anyone else share the cost of childcare for the joint children? Yes ____ No ____

C. City where childcare is provided:

5. Your Parenting Time

Is this Proposed Occurring Existing Order or Written Agreement ____

Child's Name	No. Of Overnights with You

6. Your Rebuttable Factors:

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

Are you seeking a rebuttal? (An adjustment to the support amount)

Explain: _____

B. Attach Supporting Evidence/Additional Information

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I HEREBY DECLARE THAT THE ABOVE STATEMENT IS 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: _____

Print Name: _____

I am the Petitioner: Respondent

Sign Name: _____

ATTACHEMENT CHECKLIST

<input type="checkbox"/>	Attach Proof of Monthly Medical Expenses
<input type="checkbox"/>	Four most recent pay stubs or benefit statements
<input type="checkbox"/>	Most recent state and federal tax returns (including schedules)
<input type="checkbox"/>	Proof of insurance
<input type="checkbox"/>	Proof of medical costs
<input type="checkbox"/>	Most recent parenting plan or written agreement
<input type="checkbox"/>	Proof of child care costs
<input type="checkbox"/>	Copies of Spousal and Child Support Orders
<input type="checkbox"/>	Attach Copies of Proof of Childcare expenses

UNIFORM SUPPORT AFFIDAVIT

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 EXPENSES IF IT IS**

2. FIXED COSTS:

A. RESIDENCE:

- Mortgage or Rent
- Second Mortgage
- Real Property Taxes
- Insurance, if not included
- Other:

Insurance

AMOUNT	AMOUNT
_____	_____
_____	_____
_____	_____
_____	_____

B. UTILITIES:

- Electricity:
- Heat - oil, natural gas (other than electricity)
- Water:
- Garbage:
- Telephone:
- Cable/Internet
- Cell:
- Other:

Sewer

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

C. TRANSPORTATION

- Car Payment
- Fuel
- Maintenance & Repair:
- Mass Transit:
- Other:

_____	_____
_____	_____
_____	_____
_____	_____

D. INSURANCE:

- Life:
- Automobile:
- Medical:
- Dental:
- Residence:

_____	_____
_____	_____
_____	_____
_____	_____

E: FOOD AND HOUSEHOLD ITEMS:

- (Exclude food for the children)
- Food:
- Household items:

_____	_____
_____	_____

F. CLOTHING:

- Grooming Needs:
- Clothing Needs:

_____	_____
_____	_____

G. MEDICINE & PHARMACEUTICAL

- Unreimbursed medical costs:

_____	_____
_____	_____

UNIFORM SUPPORT AFFIDAVIT

OTHER EXPENSES:

H. Court Ordered Support Payments not about this case

TOTAL FIXED COSTS (A - H)

\$0.00	\$0.00

2. CONSUMER OBLIGATIONS:

TOTAL	0		

Other expenses

Other expenses

Other expenses

Other expenses

TOTAL

0

6. TOTAL EXPENSES EXPENSES

\$0.00
