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IN THE CIRCUIT COURT OF THE STATE OF OREGON

FOR THE COUNTY OF ___________________

Family Law Department

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

SUMMARY INFORMATION – COMPLETE THIS PAGE LAST

After completing Sections 1 through 5, on Pages 2 through 5 below, insert the information and/or total **MONTHLY** amounts in this Summary Information Section. Date of Completion: ___________________.

1.	Number of Joint Children from this Relationship:	
2.	Number of Joint Children Over 18 But Under 21 Attending School:	
3.	Number of Nonjoint 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/Healthy 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:	$
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:	

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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 Page 1. Attach additional page if needed.

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):

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

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		

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4	Convert to monthly.	÷	12	
5	Gross monthly income: 1 x 2 x 3 ÷ 4			
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	
Dividends	
Interest Income	
Trust Income	
Annuity Income	
Social Security Income	
Worker's 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 Diem 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 Needy Families? ☐ **Yes, $______ monthly** ☐ **No**

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

Name of Beneficiary Child(ren)______________________ ☐ **Yes, $______ monthly** ☐ **No**

Name of Disabled Parent____________________________Source_____________________

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 to RECEIVE spousal support from a former/subsequent spouse?

☐ **Yes, $______ monthly** ☐ **No**

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1 H. *Are you ordered to PAY spousal support? ☐ **Yes, $______ monthly ☐ No**

If yes, to whom: ____

2

I. *Do you pay mandatory union dues? ☐ **Yes, $______ monthly ☐ No**

3 J. ATTACH A COPY OF YOUR FOUR MOST RECENT PAY STUB(S), BENEFIT STATEMENTS, **AND**

4 COPIES OF YOUR MOST RECENT FILED STATE AND FEDERAL TAX RETURNS.

ATTACH COPIES OF SPOUSAL SUPPORT ORDERS AND ANY CHILD SUPPORT ORDERS FOR

5 NONJOINT ADDITIONAL CHILD(REN) NOT LIVING WITH YOU.

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

7 A *Is there a cost to insure just yourself if you provide insurance for the child(ren)? ☐ YES ☐ NO

8 B Do you provide health care coverage for your joint child(ren)? ☐ YES ☐ NO

9 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: ______________________________

10 D Are you or any member of your household:

11 i. Enrolled in the Oregon Health Plan, Healthy Kids, or any other public hea care coverage? ☐ YES ☐ NO

12

ii. Receiving a state subsidy for public or private health care coverage? ☐ YES ☐ NO

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

14

Name of child(ren) enrolled?____________________________________ ☐ YES ☐ NO

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

16 i. Name **all** persons covered:____

17 Relationship to you:____

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

____

19 iii. Insurance Co. ________________________ Phone Number: _________________________

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

21

v. Policy Number:______________________ Group Number:__________________________

22

23 vi. Address for submission of claims:

____

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1 ____

2 vii. Your total monthly premium cost: (A) $______________________
Cost to cover only you: (B)*$______________________
3 Total number of people enrolled (not counting yourself): (C) $______________________
Number of joint child(ren) enrolled: (D) $______________________

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

5 viii. ATTACH PROOF OF INSURANCE PREMIUMS.

6 F. *Do you pay any out-of-pocket medical expenses (not covered by insurance) for any joint child(ren) on a monthly basis? ☐ YES ☐ NO

7 **If yes,** list the name of the child, the reason for the cost(S), and the amount per month:

8 i. ____ **$**

9 ii. ____ **$**

10 iii. ____ **$**

iv. ____ **$**

11 G Does anyone pay a share of the monthly out-of-pocket medical costs for the child(ren)? ☐ YES ☐ NO

12 **If yes,** who? ____; Amount they pay? $_______________

13

H ATTACH PROOF OF MONTHLY MEDICAL EXPENSES.

14

4. YOUR CHILDCARE EXPENSES.

15 A. *Do you pay for childcare for the joint child(ren) so you can work, train, or look for work? ☐ YES ☐ NO

16 **If yes,:**

17

Paid to:	Name of Child	Age	Average Monthly Paymen

18

19

20 B. *Does anyone else share the cost of childcare for the joint child(ren)? ☐ YES ☐ NO

21 **If yes, name:____________________________________ Average Monthly Amount $________________**

C. *City where childcare is provided:____

22 D. ATTACH COPIES OF PROOF OF CHILDCARE EXPENSES.

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1 **5.** ***YOUR PARENTING TIME**

☐ PROPOSED ☐ OCCURRING ☐ EXISTING PLAN OR WRITTEN AGREEMENT

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

3 i. Name of Child: ____________________________ # of overnights: _________

4 ii. Name of Child: ____________________________ # of overnights: _________

iii. Name of Child: ____________________________ # of overnights: _________

5 iv. Name of Child: ____________________________ # of overnights: _________

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

6. **YOUR REBUTTAL FACTORS**

7 A. The amount of child support to be paid may be rebutted under OAR 137-050-0760.

8 i. Are you seeking a rebuttal? ☐ YES ☐ NO

ii. Explain Briefly:____

9 ____

10 ____.

B. ATTACH SUPPORTING EVIDENCE/ADDITIONAL INFORMATION.

11 **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**

12 **COURT AND ARE SUBJECT TO PENALTY FOR PERJURY.**

13 DATED this ________ day of ________________________________, 2014.

14

15

16 ____

________________________, PETITIONER/RESPONDENT

17 ATTACHMENT CHECKLIST:

18

☐ Four most recent pay stubs or benefit statements	☐ Most recent parenting plan or written agreement
☐ Most recent state and federal tax returns (including all applicable schedules)	☐ Proof of child care costs
☐ Proof of insurance premiums	☐ Copies of Spousal and Child Support Orders
☐ Proof of medical costs	☐ Additional Page: Number items to correspond
	☐ Other

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1
SCHEDULE 1

2
Spousal/Registered Domestic Partner Support Factor

3
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.
4
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.**
5

6
1. FIXED COSTS

7 8 9 10 11 12 13 14 15 16 17 18 19 20

Description		**Amount**
A.	RESIDENCE:	$
	Mortgage or rent:	$
	Property Taxes (if not included in mortgage):	$
	Second mortgage/home equity loan:	$
	Insurance (if not included in mortgage):	$
B.	UTILITIES:	$
	Electricity:	$
	Gas:	$
	Water:	$
	Garbage:	$
	Telephone:	$
	Cable/Internet:	$
C.	TRANSPORTATION	
	Car Payments:	$
	Fuel:	$
	Maintenance and Repair:	$
	Other (specify):	$
D.	INSURANCE	
	Life:	$
	Automobile:	$
	Medical/Dental:	$
	Other (specify):	$
E.	FOOD AND HOUSEHOLD ITEMS:	$
F.	MEDICINE AND 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):	$

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2. CONSUMER OBLIGATIONS

	NAME OF CREDITOR	BALANCE DUE	MONTHLY AMOUNT
A			
B			
C			
D			
	TOTAL MONTHLY PAYMENTS ON CONSUMER OBLIGATONS:		**$**

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 supporting documentation whenever possible).

TOTAL:	$________________

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