IN THE COMMOM PLEAS COURT OF SUMMIT COUNTY, OHIO
DIVISION OF DOMESTIC RELATIONS

_____
Plaintiff / Petitioner (1)

Address: _____
_____

Phone: _____

Attorney _____

Attorney Address _____

Attorney telephone _____

V.

_____
Defendant / Petitioner (2) / Respondent

Address: _____
_____

Phone: _____

Attorney _____

Attorney Address _____

Attorney telephone _____

CASE NO. _____

MOTION NO. _____

SETS NO. _____

JUDGE _____

MAGISTRATE _____

Post Decree or Parentage Financial Affidavit of

_____
(Your Name)

Date of Prior Decree	

Notes: In accordance with Local Rules 2.02(B) & 2.07 of this court, this affidavit must be filed by each party with every post-decree motion or parentage case that concerns support. You will be required to provide proof of income per local rule and O.R.C. 3119.05. You are under a continuing legal duty to file an updated version of this form if you learn of any additional information. **If more space is needed, attach additional page(s).**

I. Information Required for Support Calculation:

A. Minor or Dependent Children in This Case (Include adopted children and any child of the parties who is over 18 and handicapped)

Child's Name	Date of Birth	Male / Female	Age	Residing with

B. Other Minor Children Living in My Household

Child's Name	Date of Birth	Male / Female	Age	Relationship

C. Other Minor Children of Mine, Not Living in My Household

Child's Name	Date of Birth	Male / Female	Age	Residing with

II. Child Support Guideline Adjustment:

	Father (All Figures Per Year)	**Mother** (All Figures Per Year)
Court ordered child support you pay for other child(ren) in another case		
Case Number where support ordered		
Date of initial order		
Court ordered spousal support you pay to a former spouse		
Number of **your** other dependent children living with you from a different marriage or relationship		
Is the other parent of any of your other children also in your household?	Yes No	Yes No
If yes, how many children do you have with the parent who lives with you?		
Court ordered child support you receive for the dependent child(ren) you indicated on line above (other parent not in home)		
Child care expenses you pay for child(ren) of this case (employment or educational-related)		
Local income taxes paid or rate of tax where you live or work	$ or %	$ or %
Private health insurance cost to you for children (family plan cost less individual plan cost)		
Total number of dependents covered by your insurance		
Current partner's gross income		

III. Income [As defined in O.R.C. 3119.01(C)]:

A. Gross Yearly Income from Employment (If not known, please estimate. Put "EST" after each estimated figure.)

	Father	
Gross yearly employment income		
Employer		
Payroll Address		
City, State, Zip		
Number of paychecks per year	☐12 ☐24 ☐26 ☐52	
Year-to-date Gross Income		Through date of
Prior Year's Tax Refund		

	Mother	
Gross yearly employment income		
Employer		
Payroll Address		
City, State, Zip		
Check the number of Paychecks per year	☐12 ☐24 ☐26 ☐52	
Year-to-date Gross Income		Through date of
Prior Year's Tax Refund		

B. Annual Overtime, Commissions, Bonuses (If not known, please estimate. Put "EST" after each estimated figure.)

Father		
Year 3 is Most Recent Year	Base Income	Overtime, commission, Bonuses
_____ Year 1		
_____ Year 2		
_____ Year 3		
Y-T-D This Year Through:		

Mother		
Year 3 is Most Recent Year	Base Income	Overtime, commission, Bonuses
_____ Year 1		
_____ Year 2		
_____ Year 3		
Y-T-D This Year Through:		

C. Gross Self-Employment Income (If not known, please estimate. Put "EST" after each estimated figure.) Use Gross Annual Figures for Most Recent Full Year. See O.R.C. 3119.01(C)

Father	
Business Receipts	
Ordinary & Necessary Business Expenses	
Net Business Income	

Mother	
Business Receipts	
Ordinary & Necessary Business Expenses	
Net Business Income	

D. Other Income

All other income, actual or expected, including pension, social security, workers compensation, commissions, royalties, disability benefits, trust income, annuities, reoccurring capital gains, unemployment benefits, rents, expense-sharing, dividends, interest, AFDC, SSI, food stamps, spousal support received from a prior spouse, etc. (If not known, please estimate. Put "EST" after each estimated figure.)

Father	
Describe	Per Year

Mother	
Describe	Per Year

E. Total Annual Income

Father	
Total gross annual income	
Total average gross monthly income	÷ 12 =
Average monthly deductions	Less
Total net monthly income	=

Mother	
Total gross annual income	
Total average gross monthly income	÷ 12 =
Average monthly deductions	Less
Total net monthly income	=

F.Benefits of Employment (Use of company car, country club memberships, stock options, etc.)

Father	
Benefits	Values

Mother	
Benefits	Values

IV. Private Health Insurance Information

CHECK ALL APPLICABLE BOXES AND FILL-IN ALL BLANKS.

☐ **My child(ren is/are covered by low-income government –assisted health care coverage (Healthy Start/Medicaid, etc.)**

LIST OF PLANS

I have the following **private health insurance** policies, contracts or plans to cover the child(ren) available to me.

Name of policy, contract or plan	Name of Insurance Company	Entity/group through which policy, contract or plan is available

NO PRIVATE HEALTH INSURANCE

☐ **I DO NOT HAVE the child(ren) enrolled in private health insurance because:**

- ☐ health insurance **is not available** through my employer or another group policy, contract or plan that will cover the children.
- ☐ I **declined enrollment** of the child(ren) in health insurance available through my employer or another group policy, contract or plan, but **I am enrolled in a policy, contract or plan for myself**.
- ☐ I am not yet eligible to enroll in private health insurance through employment or another group policy, contract or plan, but I will become eligible on (month/day/year) ____/____/_____.
- ☐ I expect to enroll the child(ren) when I become eligible.
- ☐ OTHER reason the child(ren) is/are not enrolled (explain): _____

CURRENT PRIVATE HEALTH INSURANCE ENROLLMENT

☐ I **DO HAVE** the child(ren) enrolled in **private health insurance** through:

- ☐ an **individual (non-group)** policy, contract or plan.
- ☐ a **group** policy, contract or plan.

Date child(ren) was/were enrolled in private health insurance: (month/day/year) ____/____/_____.

Provided through: ☐ Employer ☐ Current Spouse ☐ Other: _____

Name of Policyholder: _____
Policyholder address: _____
_____
Policyholder Phone No. (___) _____
Name of policy, contract or plan _____

Insurance Co. Name: _____
Ins. Co. Claims address _____
_____
Ins. Co. Claims Phone No. (____) _____
Group Number: _____
Identification/subscriber Number: _____

ACCESSIBILITY OF PRIMARY CARE SERVICE

My child(ren) has/have primary care services (health care/laboratory services customarily provided by a general practitioner, internal medicine, family medicine physician, or pediatrician) **accessible with this private health insurance:**

- ☐ within **30** miles of the child(ren)'s home.
- ☐ because the child(ren) **live(s)** in a geographic area where the residents customarily travel farther than 30 miles for their child(ren)'s primary care services.
- ☐ because primary care services are **only accessible by public transportation.** (Primary care services are accessible by public transportation and the person responsible for taking the child(ren) for primary care service is dependent upon public transportation).

REASONABLENESS OF COST/BEST INTEREST OF CHILDREN CONSIDERATIONS

The cost for private health insurance benefits that cover me and/or my child(ren) or will cover us when I am eligible is: (Do not include the amount than an employer or other person/entity pays for health insurance.)

Single coverage	$_____ per month
Single coverage plus one	$_____ per month
Single coverage plus two	$_____ per month
Family coverage (unlimited dependents)	$_____ per month
Other (explain): _____	$_____ per month

☐ I want to enroll/continue to have the child(ren) enrolled in the private health insurance plan in which I am currently enrolled/will become eligible to enroll in **even if the cost exceeds 5% of my TOTAL ANNUAL GROSS INCOME** (Health Insurance Maximum).

Number of Dependents currently enrolled or who will be enrolled when I become eligible: _____

Name of Dependent	Relationship to You
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

V. List any additional factors or special circumstances you believe the court should consider.

_____

_____

_____

OATH OF AFFIANT

I, _____ (print) hereby swear or affirm that the information set forth in this Affidavit of Income, Expenses, and Property above is true, complete, and accurate. *I understand that falsification of this document may result in a contempt of court finding against me which could result in a jail sentence and fine, and that falsification of this document may also subject me to criminal penalties for perjury (O.R.C. 2921.22).*

_____
AFFIANT

Sworn to and subscribed before me this _____ Day of _____, _____.

_____
Notary Public