

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

Plaintiff / Petitioner (1)

Address: _____

Phone: _____

Attorney _____

Attorney Address _____

Attorney telephone _____

CASE NO. _____

MOTION NO. _____

SETS NO. _____

JUDGE _____

MAGISTRATE _____

V.

Defendant / Petitioner (2) / Respondent

Address: _____

Phone: _____

Attorney _____

Attorney Address _____

Attorney telephone _____

**Post Decree or Parentage
Financial Affidavit of**

(Your Name)

Date of Prior Decree	
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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

Initialed _____

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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input style="width: 50px; height: 20px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input style="width: 50px; height: 20px;" type="text"/>
Is the other parent of any of your other children also in your household?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input style="width: 50px; height: 20px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input style="width: 50px; height: 20px;" type="text"/>
If yes, how many children do you have with the parent who lives with you?	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>
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		

Initialed _____

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	<input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> 26 <input type="checkbox"/> 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	<input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> 26 <input type="checkbox"/> 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.

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

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: _____

Insurance Co. Name: _____

Policyholder address: _____

Ins. Co. Claims address _____

Policyholder Phone No. (____) _____

Ins. Co. Claims Phone No. (____) _____

Name of policy, contract or plan _____

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).
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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