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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:)
,) Case No.
Petitioner,) PETITIONER'S/RESPONDENT'S
and) UNIFORM SUPPORT DECLARATION
) (Spousal and Child Support Case)
)
,)
Respondent.)

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 (Page 2, I.A):	
2	Number of joint children over 18 but under 21 attending school (Page 2, I.A):	0
3	Number of nonjoint additional children (Page 2, I.B):	0
4	Gross monthly income from all sources:	\$
5	Receiving Temporary Assistance for Needy Families?	<input type="checkbox"/> YES <input type="checkbox"/> NO
6	Child(ren) on Oregon Health Plan/Healthy Kids or other public health plan?	<input type="checkbox"/> YES <input type="checkbox"/> NO
7	Social Security or Veteran's Benefits received for child(ren):	\$
8	Spousal support RECEIVED by you:	\$
9	Spousal support PAID by you:	\$0
10	Mandatory union dues paid:	\$0
11	Health care premiums for yourself only if you provide insurance for child(ren):	\$0
12	Health care premiums paid for joint child(ren):	\$0
13	Out-of-pocket medical expenses paid for joint child(ren):	\$0
14	Number of ANNUAL overnights child(ren) spend with you:	
15	Childcare expenses paid for joint child(ren):	\$0

1 16 City where childcare is provided:

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

5 **INSTRUCTIONS:** Answer all questions. *Items marked with an * should be transferred to Page 1.* If you are
6 seeking spousal support, you need to complete Schedule 1. Attach additional page if needed.

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

9 I. **CHILDREN**

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


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


12 B. *List all NONJOINT ADDITIONAL CHILDREN

Name of Child	Age

13 II. **YOUR GROSS INCOME**

14 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	÷	12	

1	5	Gross monthly income: 1 x 2 x 3 ÷ 4		\$	
2	6	Gross monthly tips/commissions/bonuses (identify):	+	\$0	
3	Subtotal of Monthly Income From Employment (5) + (6)			SUBTOTAL: 2.A.	
4					

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

7	Description	Monthly Amount	
8	Self-Employment	\$0	
9	Dividends	\$0	
10	Interest Income	\$0	
11	Trust Income	\$0	
12	Annuity Income	\$0	
13	Social Security Income	\$0	
14	Workers' Compensation Benefits per week multiplied by 52; divided by 12	\$0	
15	Unemployment Benefits per week multiplied by 52; divided by 12	\$0	
16	Disability Income	\$0	
17	Expense Reimbursements and/or Per Diem Allowance not listed in item A. above	\$0	
18	Other (Specify source/type)	\$0	
19	Other (Specify source/type)	\$0	
20	SUBTOTAL: 2.B.		\$0
21	*Total of 2A + 2B Enter here and on Page 1, #4		TOTAL: \$0

22			Monthly Amount
23	C	*Do you receive Temporary Assistance for Needy Families? . . .	<input type="checkbox"/> YES <input type="checkbox"/> NO \$0
24	D	*Do you receive Social Security or Veteran's benefits for <u>any joint child(ren)</u> due to <u>parent's</u> disability?	<input type="checkbox"/> YES <input type="checkbox"/> NO \$0
25	E	*Do you receive Social Security or Veteran's benefits for <u>any joint child(ren)</u> due to <u>child's</u> disability?	<input type="checkbox"/> YES <input type="checkbox"/> NO \$0
26	F	*Is there an order for you to RECEIVE spousal support from <u>your spouse involved in this proceeding</u> ?	YES <input type="checkbox"/> NO \$0
27	G	*Is there an order for you to RECEIVE spousal support from a	<input type="checkbox"/> YES <input type="checkbox"/> NO \$0

1		former/subsequent spouse?		
2	H	*Are you ordered to PAY spousal support?	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$0
3	I	*Do you pay mandatory union dues?	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$0
4	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.		
5		ATTACH COPIES OF SPOUSAL SUPPORT ORDERS AND ANY CHILD SUPPORT ORDERS FOR NONJOINT ADDITIONAL CHILD(REN) NOT LIVING WITH YOU.		

8

9 **III. HEALTH CARE COVERAGE AND MEDICAL EXPENSES**

- 10 A. Is there a cost to insure just yourself if you provide insurance for the child(ren)? YES NO
- 11 B. Do you provide health care coverage for your joint child(ren)?
- 12 C. Does someone else provide health care coverage for your joint child(ren)?
- 13 D. Are you or any member of your household:
- 14 1. Enrolled in the Oregon Health Plan, Healthy Kids, or any other public health care coverage?
- 15 2. Receiving a state subsidy for public or private health care coverage? ...
- 16 E. Are any of the joint children enrolled in public health care coverage (Healthy Kids/Oregon Health Plan)?
- 17 If you answered "YES" to A, B, C, D, or E above:
- 18 1. Name ALL persons covered:
- 19 2. Relationship to you:
- 20 3. What is the source of the insurance? (such as through your employer, spouse, other):
- 21 Employer
- 22 4. Insurance Co.: Phone Number:
- 23 5. Monthly amount of any state subsidy received by your household for public or private health-care coverage: \$
- 24 6. Policy Number: Group Number:
- 25 7. Address for submission of claims:
- 26 8. Your total monthly premium cost: (A) \$0; Cost to cover only you: (B)*\$0
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) \div C = \$ ____ \times D = *\0
9. ATTACH PROOF OF INSURANCE PREMIUMS
- 23 F. *Do you pay any out-of-pocket medical expenses (not covered by insurance) for any joint child(ren) on a monthly basis?
- 24 **If yes**, list the name of the child, the reason for the cost(s), and the amount per month:
- 25
- 26 G. Does anyone pay a share of the monthly out-of-pocket medical costs for the child(ren)?
- If yes**, who; amount they pay?
- H. ATTACH PROOF OF MONTHLY MEDICAL EXPENSES.

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IV. **YOUR CHILDCARE EXPENSES**

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

PAID TO:	NAME OF CHILD:	AGE:	AVERAGE MONTHLY PAYMENT
TOTAL CHILDCARE EXPENSES (JOINT CHILDREN):			

B. Does anyone else share the cost of childcare for the joint child(ren)? YES NO
If yes, name: Average Monthly Amount:

C. City where childcare is provided:

D. ATTACH COPIES OF PROOF OF CHILDCARE EXPENSES

V. **YOUR PARENTING TIME**

PROPOSED OCCURRING EXISTING PLAN OR WRITTEN AGREEMENT

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

- 1. **Name of Child:** # of overnights:
- 2. **Name of Child:** # of overnights:
- 3. **Name of Child:** # of overnights:

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

VI. **YOUR REBUTTAL 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

- 1. Are you seeking a rebuttal (an adjustment to the support amount) Yes
- 2. Explain briefly:

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 _____, 2015.

Client, Petitioner/ Respondent

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

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- Four most recent pay stubs or benefit statements
- Most recent state and federal tax returns
- 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, include your name and case number
- Other: _____



SCHEDULE 1
Spousal/Registered Domestic Partner Support Factors

1 You must complete this schedule and prepare and submit the attachments requested in this schedule if either party
 2 seeks spousal support. These are the total household expenses you must pay each month for yourself only and not
 3 for others in your household. Utility bills should be averaged over the year. Any other annual, quarterly, or other
 4 periodic payments should be converted to a monthly average. DO NOT LIST ANY EXPENSES IF IT IS
 5 DEDUCTED FROM YOUR WAGES.

6 I. **FIXED COSTS:**

Description	Monthly Amount
A. RESIDENCE:	
Mortgage or Rent:	
Second Mortgage/Home Equity Loan:	
Property Taxes (if not included in Mortgage):	
Insurance (if not included in Mortgage):	
Repairs/maintenance:	
B. UTILITIES:	
Electricity:	
Gas:	
Water/Sewer:	
Garbage:	
Telephone (Land and cellular)	
Cable/Internet:	
C. TRANSPORTATION:	
Car Payments:	
Fuel:	
Maintenance and Repairs:	
Other (specify):	
D. INSURANCE:	
Life:	
Automobile:	
Medical/Dental:	
House/Renter's:	
Other (specify):	
E. Food and Household Items:	

1	Groceries:	
2	Dining/Eating Out:	
3	Clothing:	
4	Laundry:	
5	Grooming/personal items:	
6	Uniforms/dues/work costs:	
7	Social/Religious:	
8	Lessons/Memberships:	
9	Pets and Hobbies:	
10	Entertainment:	
11	Savings/Retirement:	
12	Travel/Vacations:	
13	Emergencies:	
14	Gifts/misc.:	
15	Other:	
16	F. Medicine & Pharmaceutical - unreimbursed medical/dental costs:	
17	Co-payments:	
18	Other:	
19	G. Court/DHR-Ordered Support Payments for other than child(ren)/spouse in this case:	
20	H. Immediate Costs:	
21	First/Last Month's Rent:	
22	Security/utility Deposit:	
23	Repairs:	
24	Legal/court fees:	
25	I. Counseling:	
26	J. Other:	
	TOTAL FIXED COSTS (A-G):	

II. CONSUMER OBLIGATIONS:

Name of Creditor	Balance Due	Monthly Payment
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A.			
B.			
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G.			
TOTAL PAYMENTS ON CONSUMER OBLIGATIONS (A-G):			

III. SUMMARY OF EXPENSES:

Description	Monthly Amount
Fixed Costs (item I. above)	
Consumer Obligations (item II. above)	
Direct Expenses of Children (Exhibit 1 attached)	
TOTAL EXPENSES:	

IV. OTHER FACTORS:

Other factors that affect my income and expense or that should be considered (attach supporting documentation whenever possible).

Exhibit 1 attached - Direct Expenses of Children

EXHIBIT 1

Direct **monthly** expenses for children of this relationship which you pay:

Description		Amount
A.	School Expenses:	
	School Lunches (not provided)	\$ 0
	Books, Tuition	\$ 0
	Activities	\$ 0
	Sports	\$ 0
	Other (specify) (year books)	\$ 0
B.	Food (other than school lunches):	\$ 0
C.	Clothing:	\$ 0
D.	Medical Insurance--Premium Payments:	\$ 0
E.	Unreimbursed Health Costs: Co-Pays	\$ 0
F.	Unreimbursed Dental Costs: Co-Pays	\$ 0
G.	Work-Related Day Care:	\$ 0
H.	Babysitting (not work related):	\$ 0
I.	Lessons:	\$ 0
J.	Grooming Needs:	\$ 0
K.	Hobbies, Recreation:	\$ 0
L.	Entertainment:	\$ 0
M.	Allowances:	\$ 0
N.	Transportation:	
	Gasoline, Oil:	\$ 0
	Insurance for Driving-Age Child:	
O.	Miscellaneous (specify):	
TOTAL DIRECT EXPENSES OF CHILDREN:		\$