

5. You are employed by: Name: _____
 Address: _____

6. Income for Wage Earner:
 A. **Gross earnings per pay period** \$ _____ How often? _____
 (weekly, every two weeks, twice per month, monthly)
 B. Other income received \$ _____ How often? _____
 (weekly, every two weeks, twice per month, monthly)
7. **Monthly** income for Self-Employed
 A. Gross Income \$ _____
 B. Other income received \$ _____
 C. Reasonable Business Expenses \$ _____
 (Itemize on attached exhibit)
 D. Self-Employment Tax \$ _____
 E. Estimated Tax Payments \$ _____
8. Are you receiving Unemployment Compensation? **Yes / No** Weekly amount: \$ _____
 For how many weeks are you eligible? _____
9. Are you receiving Social Security Supplemental Income or Social Security Disability benefits? **Yes / No**
 If yes, \$ _____ per month What date did you start receiving it? _____
10. **Work-Related** Child Care Expenses for child(ren) for whom support is being calculated: (You must attach proof of payment such as canceled checks, receipts, child care tax credit schedule, printouts or letter from child care provider.)
- A. Weekly School Year Expense Name and Address of Provider
 \$ _____

- B. Weekly Summer Expense Name and Address of Provider
 \$ _____

11. Who provides health insurance for child(ren)? _____ Father _____ Mother _____ Other
- A. Name and address of health insurance plan: _____

- B. Persons insured on plan: _____

- C. Monthly cost of **employee only** coverage for:
 health insurance \$ _____
 dental insurance \$ _____
 vision insurance \$ _____
 drug prescription insurance \$ _____

D. Monthly cost **insured is currently paying** for (including costs to add dependents):
 health insurance \$ _____
 dental insurance \$ _____
 vision insurance \$ _____
 drug prescription insurance \$ _____

E. If your employer provides a **benefit allowance** and you choose a plan which equals, exceeds, or is less than that allowance, please provide amount of allowance and your additional contribution, if any. Also, if your employer pays you for declining insurance or choosing a less expensive plan, please provide the monthly amount you receive:

12. Who claims child(ren) for income tax purposes?
 _____ Father _____ Mother **OR** _____ Alternate/Share exemptions

You file taxes as: _____ Single _____ Head of Household _____ Joint _____ Other

13. Child Support Adjustments requested: (If no adjustment is requested, do not complete this section. The requesting party must prove the basis for the adjustments.)

_____ Long Distance Parenting Time Adjustment	(+/-)\$ _____
_____ Parenting Time Adjustment	(+/-)\$ _____
_____ Income Tax Adjustment (if not sharing or alternating exemption(s))	(+/-)\$ _____
_____ Special Needs	(+/-)\$ _____
_____ Agreement Past Minority (when parent having primary residency seeks increase for child(ren) under 18)	(+/-)\$ _____
_____ Overall Financial Condition	(+/-)\$ _____

14. Attached is: _____ Current pay statement
 _____ Itemized list of reasonable business expenses
 _____ Last year's Federal Income Tax Return
 _____ W-2 (if tax return not yet completed)
 _____ Written proof of work-related child care costs
 _____ Written proof of insurance costs
 _____ Other (statement regarding requested child support adjustment(s))

I have read the above affidavit and to the best of my knowledge and belief the information is accurate and complete.

 (Your name)

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 20_____.

 NOTARY PUBLIC

My appointment expires: _____