

**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.**
)
 _____)
) **UNIFORM SUPPORT DECLARATION**
 Petitioner,) **OF PETITIONER RESPONDENT**
)
 and)
)
 _____)
)
 Respondent.)

SUMMARY INFORMATION - COMPLETE THIS PAGE LAST

After completing Sections 1 through 5, on Pages 2 through 5 below, insert the information an/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? _____
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 health insurance for the child(ren) \$ _____
12. Health care premiums paid for joint children \$ _____
13. Out-of-pocket medical expenses paid for joint children: \$ _____
14. Number of annual overnights child(ren) spends with you: _____
15. Child care expenses paid for joint children: \$ _____
16. City where child care is provided: _____

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 on the other party or their attorney. Instructions: Answer all questions. Items marked with an (*) should be transferred to Page 1. If you are seeking spousal support, you need to complete Schedule I.

1. CHILDREN

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

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

B. * List all NONJOINT ADDITIONAL CHILDREN (children under the age of 21 born to or adopted by you but not of this relationship).

Name of Child	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 amount. If paid monthly, enter 12. If paid twice monthly, enter 24. If every 2 weeks, enter 26. If every week, enter 52	x		
4	Convert to monthly amount	÷	12	
5	Gross monthly income: Line 1 x Line 2 x Line 3 ÷ Line 4			
6	Gross monthly tips, commissions or bonuses (identify)			
Subtotal of Monthly Income from Employment Line (5) + Line (6)				Subtotal 2A:

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	
Workers' Compensation Benefits per week x 52 ÷ 12	
Unemployment Benefits per week x 52 ÷ 12	
Disability Income	
Expense Reimbursement and/or Per Diem Allowance not listed in Paragraph A above	
Other (specify source/type)	
Other (specify source/type)	
SUBTOTAL 2B:	
*Total of Section 2A + 2B (Enter here and on Page 1, Item 4) TOTAL:	

Page 3 - UNIFORM SUPPORT DECLARATION OF PETITIONER RESPONDENT

HERB WEISSER, P.C.
ATTORNEY AT LAW
4614 S.W. KELLY AVENUE #202
PORTLAND, OREGON 97239
(503) 464-1072 ♦ FAX: (503) 222-0693 ♦ hdweisser@yahoo.com

C. *Do you receive Temporary Assistance for Needy Families? Yes \$ _____/mo
 No

D. *Do you receive Social Security or Veteran's Benefits for any joint children due to parent's disability? Yes \$ _____/mo
 No

Name(s) of Beneficiary Child(ren): _____
Name of Disabled Parent: _____

E. *Do you receive Social Security or Veteran's Benefits for any joint child due to child's disability? Yes \$ _____/mo
 No

Name of Disabled Child(ren): _____

F. *Is there an order for you to RECEIVE spousal support from your spouse involved in this proceeding? Yes \$ _____/mo
 No

G. *Is there an order for you to RECEIVE spousal support from a former or subsequent spouse? Yes \$ _____/mo
 No

H. *Are you ordered to PAY spousal support? Yes \$ _____/mo
 No

I. *Do you pay mandatory union dues? Yes \$ _____/mo
 No

J. **Attach copies of your four most recent paystubs, any benefit statements and copies of your most recently filed state and federal tax returns.**

Attach copies of all spousal support orders, and child support orders for nonjoint additional children not living with you.

3. HEALTH CARE COVERAGE AND MEDICAL EXPENSES

A. *Is there a cost to insure just yourself if you provide insurance for the child(ren)? Yes No

B. Do you provide health care coverage for your joint children? Yes No

C. Does someone else provide health care coverage for your joint children? Yes No

Name of person or entity providing health care coverage: _____

- D. Are you or any member of your household:
- (i) Enrolled in the Oregon Health Plan, Healthy Kids, or any other public health care coverage? Yes No
 - (ii) Receiving a state subsidy for public or private health care coverage? Yes No
- E. Are any of the joint children enrolled in public health care coverage (Oregon Health Plan/Healthy Kids)? Yes No

Name(s) of children enrolled: _____

If you answered "yes" to A, B, C, D or E above:

- (i) Name all persons covered: _____
- (ii) Relationship to you: _____
- (iii) What is the source of the insurance (e.g., employer/spouse/other)? _____
- (iv) Monthly amount of any state subsidy received by your household for public or private health care coverage: \$ _____
- (v) Policy Number _____ Group Number _____
- (vi) Address for submission of claims: _____
- (vii) Your total monthly premium cost: (A) \$ _____
 Cost to cover only you: (B) \$ _____
 Total number of people enrolled (not counting yourself) (C) _____
 Number of joint children enrolled (D) _____
 The cost for joint children only: \$ _____
 $(A - B) \div C = \$ \text{_____} \times D$

- 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

If yes, list the name of the child(ren) reason for the expense(s) and amount per month:

- (i) _____ \$ _____
- (ii) _____ \$ _____

(iii) _____ \$ _____
 (iv) _____ \$ _____

G. Does anyone pay a share of the monthly out-of-pocket medical costs for the child(ren)? Yes No

If yes, who? _____ Amount they pay: \$ _____

H. **Attach proof of monthly medical expenses**

4. YOUR CHILD CARE EXPENSES

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

If yes, complete the following:

Paid to	Name of Child	Age	Average Monthly Payment

B. Does anyone else share the cost of child care for the joint children? Yes No
 If yes, who? _____ Average monthly amount paid: \$ _____

C. City where child care is provided: _____

D. **Attach proof of child care expenses**

5. *YOUR PARENTING TIME

Proposed Occurring Existing Plan or Written Agreement

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

i. Name of child: _____ No. of overnights: _____
 ii. Name of child: _____ No. of overnights: _____
 iii. Name of child: _____ No. of overnights: _____
 iv. Name of child: _____ No. of overnights: _____

B. **Attach a copy of most recent parenting plan or written agreement**

5. **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

i. Are you seeking a rebuttal (an adjustment to the support amount)? Yes No

ii. Explain: _____

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 _____.

(name)
Petitioner/Respondent/Co-Petitioner

ATTACHMENT CHECKLIST

- Four most recent paystubs or benefit statements
- Most recent state and federal tax returns (including applicable schedules)
- Proof of health insurance premiums
- Proof of medical costs
- Most recent parenting plan or written agreement
- Proof of child care costs
- Copies of spousal and child support orders
- Additional pages (number to correspond with section numbers, include your name and case number)
- Other: _____

SCHEDULE 1
Spousal/Registered Domestic Partner Support Factors

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 pay each month for yourself only, and not for others in your household. 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.

1. 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)	
B. UTILITIES	
Electricity	
Gas	
Water	
Garbage	
Telephone	
Cable/Internet	
C. TRANSPORTATION	
Car Payment(s)	
Fuel	
Maintenance and repairs	
Other (specify)	
D. INSURANCE	
Life	
Automobile	
Medical/Dental	
Other (specify)	

E. FOOD AND HOUSEHOLD ITEMS	
F. MEDICINE/PHARMACEUTICAL (unreimbursed medical/dental costs)	
G. Court/DHR - ordered support payments for other than joint child(ren)	
TOTAL FIXED COSTS (A - G)	

2. CONSUMER OBLIGATIONS

	Name of Creditor	Balance Due	Monthly Amount
A.			
B.			
C.			
D.			
E.			
F.			
TOTAL PAYMENTS ON CONSUMER OBLIGATIONS (A - F)			

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, or expense that should be considered (attach supporting documentation whenever possible):