IN THE CIRCUIT COURT OF THE STATE OF OREGON
FOR _____ COUNTY

In the Matter of:	Case No. _____
_____,	Judge Assigned: _____
☐ Petitioner ☐ Co-Petitioner,	Check one box: ☐ PETITIONER'S ☐ RESPONDENT'S ☐ CO-PETITIONER'S ☐ CO-RESPONDENTS or ☐ OTHER: _____
and	
_____,	**UNIFORM SUPPORT DECLARATION**
☐ Respondent ☐ Co-Respondent.	OR CSP Case No. _____

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 _____ mm/dd/year

1. Number of Joint Children From This Relationship: 1
2. Number of Joint Children Over 18 But Under 21 Attending School: 0
3. Number of Nonjoint Additional Children: 0
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? ☐ **Yes** ☐ **No**
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 Insurance for Child(ren): $_____
12. Health Care Premiums Paid for Joint Child(ren): $_____
13. Out-of-Pocket Medical Expenses Paid for Joint Child(ren): $_____
14. Number of ANNUAL Overnights Child(ren) Spends With You: _____
15. Childcare Expenses Paid for Joint Child(ren): $_____
16. City Where Childcare 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 upon 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 1. Attach additional page if needed.

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

1. CHILDREN

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

		Children Living With:			Over 18 & Under 21 Attending School	
Name of Child	Age	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	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. 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**	
5	Gross monthly income: 1. x 2. x 3. ÷ 4.			
6	Gross monthly tips/commissions/bonuses (identify):			
Subtotal of Monthly Income From Employment (5) + (6)			**SUBTOTAL: 2.A.**	

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 multiplied by 52; divided by 12	
Unemployment Benefits per week multiplied by 52; divided by 12	
Disability Income	
Expense Reimbursements and/or Per Diem Allowance not listed in item A. above	
Other (specify source/type) ☐	
Other (specify source/type): ☐	
SUBTOTAL: 2.B.	
***Total of 2A + 2B Enter here and on Page 1, #4** **TOTAL:**	

C. *Do you receive Temporary Assistance for Needy Families? ☐ **Yes, $_____ monthly** ☐ **No**

D. *Do you receive Social Security or Veteran's benefits for any joint child(ren) due to parent's disability?

Name of Beneficiary Child(ren) _____ ☐ **Yes, $_____ monthly** ☐ **No**

Name of Disabled Parent _____ Source _____

E. *Do you receive Social Security or Veteran's benefits for any joint child(ren) due to child's disability?

☐ **Yes, $_____ monthly** ☐ **No**

Name of Child(ren) _____ Source _____

F. *Is there an order for you to RECEIVE spousal support from your spouse involved in this proceeding?

☐ **Yes, $_____ monthly** ☐ **No**

G. *Is there an order for you to RECEIVE spousal support from a former/subsequent spouse?

☐ **Yes, $_____ monthly** ☐ **No**

H. *Are you ordered to PAY spousal support? ☐ **Yes, $_____ monthly** ☐ **No**

If Yes, to whom? _____

I. *Do you pay mandatory union dues? ☐ **Yes, $_____ monthly** ☐ **No**

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.

ATTACH COPIES OF SPOUSAL SUPPORT ORDERS AND ANY CHILD SUPPORT ORDERS FOR NONJOINT ADDITIONAL CHILD(REN) 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 child(ren)? ☐ **Yes** ☐ **No**

C. Does someone else provide health care coverage for your joint child(ren)? ☐ **Yes** ☐ **No**

Name of person, or entity, providing, if other than you: _____

D. Are you or <u>any member of your household:</u>

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 (Healthy Kids/Oregon Health Plan)?

Name of child(ren) enrolled? _____ ☐ **Yes** ☐ **No**

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

i. Name **all** persons covered: _____

Relationship to you: _____

ii. What is the source of the insurance? (such as through your employer, spouse, other): _____

_____

iii. Insurance Co.: _____ Phone Number: _____

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 the joint child(ren) only is (A – B) ÷ C = $_____ x D = *$_____

viii. ATTACH PROOF OF INSURANCE PREMIUMS.

F. *Do you pay any <u>out-of-pocket</u> 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, the reason for the cost(s), and the amount <u>per month</u>:

i. _____; $_____

ii. _____; $_____

iii. _____; $_____

iv. _____; $_____

G. Does <u>anyone</u> 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 CHILDCARE EXPENSES

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

If yes,:

Paid to:	Name of Child	Age	Average Monthly Payment

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.

5. *YOUR PARENTING TIME

☐ PROPOSED ☐ OCCURRING ☐ EXISTING PLAN OR WRITTEN AGREEMENT

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

i. Name of Child: _____ # of overnights: _____

ii. Name of Child: _____ # of overnights: _____

iii. Name of Child: _____ # of overnights: _____

iv. Name of Child: _____ # of overnights: _____

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

6. 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 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 _____, 20___.

My (printed) Name Is _____

I am:

☐ PETITIONER ☐ RESPONDENT ☐ CO-PETITIONER

☐ OTHER: _____

_____

SIGNATURE

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

- ☐ Four most recent pay stubs or benefit statements
- ☐ Most recent state and federal tax returns (including all applicable schedules)
- ☐ 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: _____

CERTIFICATE OF MAILING

I hereby certify that I served a true and complete copy of this Uniform Support Declaration and all attachments by mailing it first class mail, with postage prepaid, on _____ (date) to the following people:

1. _____ (Other Party/Attorney name)
   Address: _____
   _____
2. _____ (name)
   Address: _____
   _____

_____
SIGNATURE

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 must 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 Payments	
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 child(ren)/spouse/RDP in this case	
TOTAL FIXED COSTS (A-G):	

2. **CONSUMER OBLIGATIONS:**

	Name of Creditor	Balance Due	Monthly Amount
A.	American Express		
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 and expense or that should be considered (attach supporting documentation whenever possible).

TOTAL:	

My (printed) Name is: _____

I am:

☐ PETITIONER ☐ RESPONDENT

☐ CO-PETITIONER

☐ OTHER: _____