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

In the Matter of: , Petitioner, and , Respondent.	Case No. _____ Judge Assigned: _____ Check one box: □ PETITIONER'S □ RESPONDENT'S □ CO-PETITIONER'S □ CO-RESPONDENT'S □ OTHER _____ **UNIFORM SUPPORT DECLARATION** 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	
2. Number of Joint Children Over 18 but Under 21 Attending School	
3. Number of Nonjoint Additional Children	
4. Grossly 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 Insurance for Child(ren):	
12. Health Care Premiums Paid for Joint Child(ren):	
13. Out-of Pocket Medical Expenses Paid for Joint Children:	
14. Number of Annual Overnights Child (ren) Spends with You:	
15. Childcare Expenses Paid for Joint Child(ren):	
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 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"

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 form 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 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 (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 that 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 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, the reason for the cost(s), and the 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 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 _____, 2010.

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 parenting plan or written agreement
☐ Most recent state and federal tax returns (including all applicable schedules)	☐ Proof of childcare costs
☐ Proof of insurance premiums	☐ Copies of Spousal and Child Support Orders
☐ Proof of medical costs	☐ 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 _____, 2010.

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 & 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):		$ 0.00

2. CONSUMER OBLIGATIONS:

NAME OF CREDITOR		BALANCE DUE	MONTHLY PAYMENTS
A.			
B.			
C.			
D.			
E.			
F.			
TOTAL PAYMENTS ON CONSUMER OBLIGATIONS (A-F):			$0.00

3. SUMMARY OF EXPENSES:

Description	Monthly Amount
Fixed Costs (item 1 above)	$ 0.00
Consumer Obligations (item 2 above)	$ 0.00
TOTAL EXPENSES:	$ 0.00

4. Other Factors:
Other factors that affect my income and expenses or that should be considered (attach supporting documentation whenever possible).

TOTAL :	

My (printed) Name is:_____
I am:
□ PETITIONER □ RESPONDENT
□ CO-PETITIONER
□ OTHER: _____