Sandusky County CSEA
2511 Countryside Dr Ste A
Fremont OH 43420

Telephone Number: 419-334-2909
Toll Free Number: 1-800-883-8283
Fax Number: 419-355-5344
CSEA Website: info@sanduskycountydjfs.org

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Date:

Case Number:
Order Number:

Child Support Obligor:
Child Support Obligee:

Ohio Department of Job and Family Services

# CHILD SUPPORT FINANCIAL AFFIDAVIT

**The information requested below is needed for the CSEA to accurately calculate the amount of child support to be paid and to allocate the costs of providing for the health care needs of the children between the parents. Please complete each applicable field clearly, providing the most information you can, including any partial information. Please supply copies of any information requested. If you need additional space to provide complete responses, please attach additional pages.**

| **A. YOUR INFORMATION** | | | |
|---|---|---|---|
| Last Name | First Name | | Middle Initial |
| Residential Address | | | Apartment/Unit # |
| City | State | | Zip |
| Mailing Address | | | Apartment/Unit # |
| City | State | | Zip |
| Date of Birth | SSN | Email | |
| Home Phone | Cell Phone | Other Phone(s) | |

| **B. LIST THE MINOR CHILDREN OF THIS ORDER** | | | |
|---|---|---|---|
| Child 1 | SSN | DOB | Does this child primarily reside with you? ☐ YES ☐ NO |
| Child 2 | SSN | DOB | Does this child primarily reside with you? ☐ YES ☐ NO |
| Child 3 | SSN | DOB | Does this child primarily reside with you? ☐ YES ☐ NO |
| Child 4 | SSN | DOB | Does this child primarily reside with you? ☐ YES ☐ NO |

**C. CHILD CARE COSTS FOR THE CHILDREN OF THIS ORDER**

Do you pay child care for children of this order so that you can go to work or activities related to employment training?
☐ YES ☐ NO

Child's name: _____ Amount $_____/annually

Child's name: _____ Amount $_____/annually

Child's name: _____ Amount $_____/annually

Child's name: _____ Amount $_____/annually

**If you answered yes, you must attach proof of payments in the form of receipts, canceled checks, or notarized statement from the child care provider.**

## D. SOCIAL SECURITY BENEFITS FOR THE CHILDREN OF THIS ORDER

Do any of your children of this order receive Social Security benefits based upon a parent's disability? ☐ YES ☐ NO

Child's name: _____ Amount $_____/month Due to ☐ My disability OR ☐ Other Parent's

Child's name: _____ Amount $_____/month Due to ☐ My disability OR ☐ Other Parent's

Child's name: _____ Amount $_____/month Due to ☐ My disability OR ☐ Other Parent's

Child's name: _____ Amount $_____/month Due to ☐ My disability OR ☐ Other Parent's

**If you filled out this section, you must attach proof (i.e. an award letter) of the frequency and amount of the monthly benefits.**

## E. DO YOU HAVE OTHER NATURAL OR ADOPTED MINOR CHILDREN NOT LISTED ABOVE? ☐ YES ☐ NO

| Name | DOB | Does this child live with you? ☐ YES ☐ NO<br>Case No. _____<br>County/State _____ |
|---|---|---|
| Name | DOB | Does this child live with you? ☐ YES ☐ NO<br>Case No. _____<br>County/State _____ |
| Name | DOB | Does this child live with you? ☐ YES ☐ NO<br>Case No. _____<br>County/State _____ |
| Name | DOB | Does this child live with you? ☐ YES ☐ NO<br>Case No. _____<br>County/State _____ |

**If you filled out this section, you must attach copies of birth certificate(s), adoption order(s), and/ or copies of order(s).**

## F. SPOUSAL SUPPORT

Do you receive Spousal Support? ☐ YES ☐ NO I receive $_____/month
County/State _____

Do you pay Spousal Support? ☐ YES ☐ NO I pay $_____/month
County/State _____

## G. MILITARY Attach a copy of your Leave and Earnings Statement (LES)

Do you receive pay from the military? ☐ YES ☐ NO Basic $_____/mo. BAS $_____/mo.
BAH/Q $_____/mo. Other military pay $_____/mo.

Rank _____ Branch _____ Years of Service _____

**Military Status:**
☐ Active ☐ Reserve ☐ Retired ☐ Other

## H. EMPLOYMENT INFORMATION

**Are you employed?** ☐ YES If yes, when did you begin employment? _____ ☐ NO If NO, skip to section I. Work History

| Employer 1 | Address<br>*(Payroll address, if different)* | Phone |
|---|---|---|
| ☐ Full Time ☐ Part Time ☐ Seasonal | Paychecks received ☐ Weekly ☐ Bi-Weekly ☐ Monthly<br>☐ Other _____ | |
| ☐ Salary $_____/ per month ☐ Hourly $_____/per hr | Hours Worked Per Week _____ | |
| ☐ Overtime $_____ Last Year $_____ | 2 Years ago $_____ 3 Years ago | |
| ☐ Bonuses $_____ Last Year $_____ | 2 Years ago $_____ 3 Years ago | |
| ☐ Commission $_____ Last Year $_____ | 2 Years ago $_____ 3 Years ago | |

**Do you have a second job?** ☐ YES ☐ NO

| Employer 2 | Address<br>*(Payroll address, if different)* | Phone |
|---|---|---|
| ☐ Full Time ☐ Part Time ☐ Seasonal | Paychecks received ☐ Weekly ☐ Bi-Weekly ☐ Monthly<br>☐ Other _____ | |
| ☐ Salary $_____/per month ☐ Hourly $_____/per hr | Hours Worked Per Week _____ | |
| ☐ Overtime $_____ Last Year $_____ | 2 Years ago $_____ 3 Years ago | |

☐ Bonuses $_____ Last Year $_____ 2 Years ago $_____ 3 Years ago

☐ Commission $_____ Last Year $_____ 2 Years ago $_____ 3 Years ago

**ARE YOU SELF EMPLOYED?** ☐ YES ☐ NO

Name of business: _____

Type of business: _____

Self-employment total gross receipts: $_____

Ordinary and necessary business expenses: $_____

## I. WORK HISTORY

**LIST YOUR LAST 3 EMPLOYERS:**

Employer Name & Address: _____ Date of employment: _____ to _____

Last Pay Rate $_____ Reason for leaving: _____

Employer Name & Address: _____ Date of employment: _____ to _____

Last Pay Rate $_____ Reason for leaving: _____

Employer Name & Address: _____ Date of employment: _____ to _____

Last Pay Rate $_____ Reason for leaving: _____

My usual occupation is _____ Last grade of school completed _____

Degree(s), Certificate(s), or Professional License(s): _____

Are you medically disabled? ☐ YES ☐ NO **If yes, provide proof of disability.**

## J. DO YOU RECEIVE FUNDS FROM THE FOLLOWING SOURCES? Check all that apply and attach verification

☐ I receive $_____ per _____ from pensions or retirement accounts _____ *(list sources)*

☐ I receive $_____ per _____ from Supplemental Security Income (SSI)

☐ I receive $_____ per _____ from Social Security Disability Benefits (SSD)

☐ I receive $_____ per _____ from annuities and/or dividends and/or other investment income

☐ I receive $_____ per _____ from rental property

☐ I receive $_____ per _____ from unemployment compensation

☐ I receive $_____ per _____ from Worker's Compensation

☐ I receive $_____ per _____ from _____ *(list sources)*

Do you have a pending claim from an above source? ☐ YES ☐ NO If yes, list source _____

**If you are not employed and do not receive any of the above benefits, please explain how you support yourself.**

## K. MANDATORY DEDUCTIONS Attach a copy of last year's completed tax form

Do you pay required union dues/uniform /work expenses? ☐ YES ☐ NO If yes, amount $_____ per _____

## L. HEALTH INSURANCE INFORMATION Attach copies of all health insurance cards

Do you currently have health insurance coverage? ☐ YES ☐ NO If yes, beginning date of coverage _____

Is this health insurance available through: ☐ Employer ☐ Spouse's Employer ☐ State *(i.e. Medicaid, etc.)*
☐ Other _____

Do the child(ren) have health care coverage? ☐ YES ☐ NO If no, is health insurance coverage available? ☐ YES ☐ NO

If yes, beginning date of coverage _____

Is this health insurance available through: ☐ Employer ☐ Spouse's Employer ☐ State *(i.e. Medicaid, etc.)*
☐ Other _____

If coverage is provided or is available through your current spouse, please provide the following information about your spouse:

Spouse's name: _____ Spouse's SSN: _____

Spouse's address, if different from yours: _____ Spouse's DOB: _____

List individuals currently covered by available health insurance:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name of health insurance company or union *(provide union local number)*: _____

Address: _____

Phone number: _____ Policy holder name: _____

Policy number: _____ Group number: _____ Type of insurance *(i.e. medical, dental, etc)*: _____

Name of health insurance company or union *(provide union local number)*: _____

Address: _____

Phone number: _____ Policy holder name: _____

Policy number: _____ Group number: _____ Type of insurance *(i.e. medical, dental, etc)*: _____

Please attach an additional sheet to supply information about any additional health insurance plans that provide coverage for the child(ren). **Please attach copies of all health insurance cards.**

| **M. COST OF HEALTH CARE INSURANCE IF AVAILABLE, REGARDLESS OF WHETHER YOU CURRENTLY CARRY IT** | |
|---|---|
| Medical | Total, actual out-of-pocket cost to provide medical care coverage for the child(ren): $_____/month |
| Dental | Total, actual out-of-pocket cost to provide dental care coverage for the child(ren): $_____/month |
| Vision | Total, actual out-of-pocket cost to provide vision care coverage for the child(ren): $_____/month |

## N. DOCUMENTATION PROVIDED AND SIGNATURE

I have attached the following documentation *(check all that apply)*:

- ☐ W-2's, IRS 1099, and all other IRS forms and schedules from last year. If self employed, I have attached the previous three years of returns, including all accompanying schedules.
- ☐ Six months of pay stubs and, if applicable, all other records evidencing receipt of any other salary, wages, or compensation
- ☐ Disability letter from Workers Compensation or Social Security or a letter from a certified health care provider with my diagnosis and a determination stating how long I will be unable to work
- ☐ Proof of any other non-employment income
- ☐ Copies of health insurance cards
- ☐ Proof of my out-of-pocket costs to provide health insurance for my child(ren)
- ☐ Proof of my out-of-pocket costs to provide child day care for my child(ren) while I'm at work or school
- ☐ Proof of the amount of social security received by my child due to my or the other parent's disability or retirement
- ☐ Proof of children born or adopted by me not of this order (birth certificate, adoption decree)

**NOTICE:** Failure to provide all information and documentation necessary to support my request could result in the agency requesting the court of appropriate jurisdiction of the county in which the agency is located to issue an order requiring the parent to provide the information as requested, or making reasonable assumptions on the information the parent failed to provide and proceed with determining support as if all requested information had been provided. In addition, your employer could be subpoenaed, requiring them to produce records regarding your income and health care information. If you have any questions, please do not hesitate to contact the <County Name> County CSEA.

I hereby swear or affirm that the information contained or attached is true, correct and complete to the best of my knowledge.

| _____ | _____ | _____ |
|---|---|---|
| Signature | Print Name | Date |