Wood County Child Support Enforcement Agency

1940 East Gypsy Lane Road
Po Box 1028
Bowling Green Ohio 43402

Phone: 419-354-9270
Toll Free: 866-861-0657
Fax: 419-354-9371
childsupport.co.wood.oh.us

Case Number: _____ Order Number: _____ Date: _____

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 - STREET:	CITY:	STATE:	ZIP:
MAILING ADDRESS - STREET:	CITY:	STATE:	ZIP:
DOB:	SSN:	EMAIL:	
HOME PHONE:	CELLPHONE:	OTHER PHONE(S):	

B. List the Minor Child(ren) 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. Day Care Costs for the Child(ren) of This Order

DO YOU PAY DAY CARE FOR CHILDREN OF THIS ORDER SO THAT YOU CAN GO TO WORK OR SCHOOL? ☐ 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 Child(ren) of This Order

DO ANY OF YOUR CHILD(REN) RECEIVE SOCIAL SECURITY BENEFITS BASED UPON A PARENT'S DISABILITY? ☐ YES ☐ NO

CHILD'S NAME: _____ AMOUNT $_____/MONTH DUE TO ☐ MOM'S DISABILITY OR ☐ DAD'S DISABILITY

CHILD'S NAME: _____ AMOUNT $_____/MONTH DUE TO ☐ MOM'S DISABILITY OR ☐ DAD'S DISABILITY

CHILD'S NAME: _____ AMOUNT $_____/MONTH DUE TO ☐ MOM'S DISABILITY OR ☐ DAD'S DISABILITY

CHILD'S NAME: _____ AMOUNT $_____/MONTH DUE TO ☐ MOM'S DISABILITY OR ☐ DAD'S DISABILITY

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

NAME: _____ DOB:_____ DOES THIS CHILD LIVE WITH YOU? ☐ YES ☐ NO

NAME: _____ DOB:_____ DOES THIS CHILD LIVE WITH YOU? ☐ YES ☐ NO

NAME: _____ DOB:_____ DOES THIS CHILD LIVE WITH YOU? ☐ YES ☐ NO

If you filled out this section, you must attach copies of birth certificate(s), and/or adoption 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 $_____/MONTH BAS $_____/MONTH BAH $_____/MONTH

RANK: _____ BRANCH: _____ YEARS OF SERVICE: _____

MILITARY STATUS: ☐ ACTIVE ☐ RESERVE ☐ RETIRED ☐ OTHER

H. Employment Information

ARE YOU EMPLOYED? ☐ YES ☐ NO IF YES, WHEN DID YOU BEGIN EMPLOYMENT? (IF NO, SKIP TO SECTION I):

EMPLOYER 1:	ADDRESS: (PAYROLL ADDRESS, IF DIFFERENT):	PHONE:

☐ FULL TIME ☐ PART TIME ☐ SEASONAL PAYCHECKS RECEIVED ☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ 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: (PAYROLL ADDRESS, IF DIFFERENT):	PHONE:

☐ FULL TIME ☐ PART TIME ☐ SEASONAL PAYCHECKS RECEIVED ☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ 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: $_____	SELF-EMPLOYMENT TOTAL GROSS RECEIPTS: $_____

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. City Taxes and Other Mandatory Deductions (Attach a Copy of Last Year's Completed Tax Form)

DO YOU PAY LOCAL (CITY) INCOME TAX? ☐ YES ☐ NO IF YES, AMOUNT $____________________ PER ____________________

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: ____

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): ____________________

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	SINGLE COVERAGE COST: $_________/MO.	SINGLE PLUS DEPENDENT COST: $_________/MO.	FAMILY COST: $___________/MO.
DENTAL	SINGLE COVERAGE COST: $_________/MO.	SINGLE PLUS DEPENDENT COST: $_________/MO.	FAMILY COST: $___________/MO.
VISION	SINGLE COVERAGE COST: $_________/MO.	SINGLE PLUS DEPENDENT COST: $_________/MO.	FAMILY COST: $___________/MO.

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)
- ☐ Proof of the amount of social security received by my child due to 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