

Clermont County CSEA  
 2400 Clermont Center Drive  
 Suite 107  
 Batavia, Ohio 45103

Telephone Number: 513-732-7248  
 Toll Free Number: 1-800-571-0943  
 Fax Number: 513-732-7444  
 CSEA Website: ClermontSupportsKids.org

Parent Name  
 Parent Address

City, State Zip  
 Country

Case Number: \_\_\_\_\_ Date: \_\_\_\_\_  
 Order Number: \_\_\_\_\_ Child Support Obligor: \_\_\_\_\_  
 Child Support Oblige: \_\_\_\_\_

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? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Child 2	SSN	DOB	Does this child primarily reside with you? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Child 3	SSN	DOB	Does this child primarily reside with you? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Child 4	SSN	DOB	Does this child primarily reside with you? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Child's name: _____	Amount \$_____/month	Due to <input type="checkbox"/> My disability OR <input type="checkbox"/> Other Parent's
Child's name: _____	Amount \$_____/month	Due to <input type="checkbox"/> My disability OR <input type="checkbox"/> Other Parent's
Child's name: _____	Amount \$_____/month	Due to <input type="checkbox"/> My disability OR <input type="checkbox"/> Other Parent's
Child's name: _____	Amount \$_____/month	Due to <input type="checkbox"/> My disability OR <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Name _____	DOB _____	Does this child live with you? <input type="checkbox"/> YES <input type="checkbox"/> NO Case No. _____ County/State _____
Name _____	DOB _____	Does this child live with you? <input type="checkbox"/> YES <input type="checkbox"/> NO Case No. _____ County/State _____
Name _____	DOB _____	Does this child live with you? <input type="checkbox"/> YES <input type="checkbox"/> NO Case No. _____ County/State _____
Name _____	DOB _____	Does this child live with you? <input type="checkbox"/> YES <input type="checkbox"/> NO Case No. _____ 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? <input type="checkbox"/> YES <input type="checkbox"/> NO I receive \$_____/month County/State _____
Do you pay Spousal Support? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO Basic \$_____/mo. BAS \$_____/mo. BAH/Q \$_____/mo. Other military pay \$_____/mo.
Rank _____ Branch _____ Years of Service _____
<b>Military Status:</b> <input type="checkbox"/> Active <input type="checkbox"/> Reserve <input type="checkbox"/> Retired <input type="checkbox"/> Other

H. EMPLOYMENT INFORMATION
<b>Are you employed?</b> <input type="checkbox"/> YES If yes, when did you begin employment? _____ <input type="checkbox"/> NO If NO, skip to section I. Work History
Employer 1 Address _____ Phone _____ (Payroll address, if different)
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal Paychecks received <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____
<input type="checkbox"/> Salary \$_____/per month <input type="checkbox"/> Hourly \$_____/per hr Hours Worked Per Week _____
<input type="checkbox"/> Overtime \$_____ Last Year \$_____ 2 Years ago \$_____ 3 Years ago
<input type="checkbox"/> Bonuses \$_____ Last Year \$_____ 2 Years ago \$_____ 3 Years ago
<input type="checkbox"/> Commission \$_____ Last Year \$_____ 2 Years ago \$_____ 3 Years ago
<b>Do you have a second job?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
Employer 2 Address _____ Phone _____ (Payroll address, if different)
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal Paychecks received <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____
<input type="checkbox"/> Salary \$_____/per month <input type="checkbox"/> Hourly \$_____/per hr Hours Worked Per Week _____
<input type="checkbox"/> Overtime \$_____ Last Year \$_____ 2 Years ago \$_____ 3 Years ago

<input type="checkbox"/> Bonuses	\$_____ Last Year	\$_____ 2 Years ago	\$_____ 3 Years ago
<input type="checkbox"/> Commission	\$_____ Last Year	\$_____ 2 Years ago	\$_____ 3 Years ago
<b>ARE YOU SELF EMPLOYED?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			
Name of business: _____		Self-employment total gross receipts: \$_____	
Type of business: _____		Ordinary and necessary business expenses: \$_____	
<b>I. WORK HISTORY</b>			
<b>LIST YOUR LAST 3 EMPLOYERS:</b>			
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? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>If yes, provide proof of disability.</b>			
<b>J. DO YOU RECEIVE FUNDS FROM THE FOLLOWING SOURCES? Check all that apply and attach verification</b>			
<input type="checkbox"/> I receive \$_____ per _____ from pensions or retirement accounts _____ ( <i>list sources</i> )			
<input type="checkbox"/> I receive \$_____ per _____ from Supplemental Security Income (SSI)			
<input type="checkbox"/> I receive \$_____ per _____ from Social Security Disability Benefits (SSD)			
<input type="checkbox"/> I receive \$_____ per _____ from annuities and/or dividends and/or other investment income			
<input type="checkbox"/> I receive \$_____ per _____ from rental property			
<input type="checkbox"/> I receive \$_____ per _____ from unemployment compensation			
<input type="checkbox"/> I receive \$_____ per _____ from Worker's Compensation			
<input type="checkbox"/> I receive \$_____ per _____ from _____ ( <i>list sources</i> )			
Do you have a pending claim from an above source? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list source _____			
<b>If you are not employed and do not receive any of the above benefits, please explain how you support yourself.</b>			
<b>K. MANDATORY DEDUCTIONS Attach a copy of last year's completed tax form</b>			
Do you pay required union dues/uniform /work expenses? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, amount \$_____ per _____			
<b>L. HEALTH INSURANCE INFORMATION Attach copies of all health insurance cards</b>			
Do you currently have health insurance coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, beginning date of coverage _____			
Is this health insurance available through: <input type="checkbox"/> Employer <input type="checkbox"/> Spouse's Employer <input type="checkbox"/> State ( <i>i.e. Medicaid, etc.</i> )			
<input type="checkbox"/> Other _____			
Do the child(ren) have health care coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, is health insurance coverage available? <input type="checkbox"/> YES <input type="checkbox"/> NO			
If yes, beginning date of coverage _____			
Is this health insurance available through: <input type="checkbox"/> Employer <input type="checkbox"/> Spouse's Employer <input type="checkbox"/> State ( <i>i.e. Medicaid, etc.</i> )			
<input type="checkbox"/> 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 \_\_\_\_\_

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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*): \_\_\_\_\_

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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.**

<b>M. COST OF HEALTH CARE INSURANCE IF AVAILABLE, REGARDLESS OF WHETHER YOU CURRENTLY CARRY IT</b>	
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