

NEW REQUEST

DISTRICT COURT, _____ COUNTY, COLORADO	
THE PEOPLE OF THE STATE OF COLORADO: IN THE INTEREST OF: _____, CHILD/REN, UPON THE PETITION OF JEEFERSON COUNTY DEPARTMENT OF HUMAN SERVICES AND _____, PETITIONERS, AND CONCERNING: _____, RESPONDENT	^ COURT USE ONLY ^ CASE NUMBER: _____ DIVISION/COURTROOM: _____ IV-D CASE NUMBER: 30-_____
Attorney or Party Without Attorney: JEFFERSON COUNTY CHILD SUPPORT ENFORCEMENT UNIT 3500 ILLINOIS ST SUITE 1300 GOLDEN, CO 80401 (303) 271-4300	
AFFIDAVIT WITH RESPECT TO CHILD SUPPORT	

INSTRUCTIONS:

PLEASE PRINT IN INK OR TYPE. COMPLETE EACH QUESTION WITH A CHECK MARK OR AN X IN THE BOX PROVIDED OR ENTER THE INFORMATION REQUESTED. IF YOU HAVE NO KNOWLEDGE OF THE INFORMATION REQUESTED, ENTER "DON'T KNOW." **DO NOT** LEAVE ANY QUESTIONS UNANSWERED, EXCEPT AS INSTRUCTED. IF ANY INFORMATION CHANGES AFTER THE AFFIDAVIT IS COMPLETE, NOTIFY THE CHILD SUPPORT ENFORCEMENT (CSE) UNIT OF THE CHANGES. ATTACH REQUESTED DOCUMENTS OR PROOF.

YOUR PERSONAL DATA

Name (First, Middle, Last): _____

Social Security Number: _____ Date of Birth: _____
 Address: _____
 City, State Zip: _____
 Phone Number: _____

Provision of your social security number is mandatory pursuant to 42 U.S.C. 666(a)(13). Social security numbers are used by the Division of Child Support Enforcement to locate individuals for the purposes of establishing paternity, establishing support obligations, modifying and enforcing child support obligations and distribution of child support payments. If you do not have a social security number, the Division will not deny your request for assistance.

YOUR PRIMARY EMPLOYMENT

- ____ Attached are IRS Tax returns for the last 3 years.
- ____ Attached are pay statements for the last three months.
- ____ If self-employed, attached are personal and business income tax returns, including all schedules and forms (especially Form K-1, Form 1065, Form 1120S, or Form 1120C) for the last three tax years.
- ____ If self-employed, attached are income and expense balance sheets for each month since last business tax return filed.

Current/Previous [Employer] [Business]: _____

Address: _____
 City, State Zip: _____
 Phone Number: _____

Date Employment (Business) began: _____

Current Position began on: _____

Hours worked each week: _____ Hourly wage \$ _____ Salary \$ _____

How often do you get paid? ___ weekly ___ every 2 weeks ___ twice a month ___ monthly

Monthly Gross Income: \$ _____

Bonus: \$ _____ Frequency: _____

Tips: \$ _____ Frequency: _____

Commission: \$ _____ Frequency: _____

Overtime is \$ _____ per hour. Frequency (weekly, monthly, every 2 weeks): _____

____ Overtime is not available. ____ Overtime is required.

Year to date Total Gross Income: \$ _____

If unemployed, what date did you last work? _____

I am unemployed due to ___ disability ___ involuntary layoff at work ___ other. Please Explain; _____

Are you receiving unemployment compensation? Check one: ___ Yes ___ No

- If you are unemployed due to disability, please attach documentation of your

disability and/or disability insurance or Social Security benefit.

- If you are receiving unemployment compensation, please attach documentation of the weekly benefit.

I am a full time student. Expected graduation date: _____ (Attach proof of status).

I am incarcerated. Attach proof of expected release date and/or parole date.

DOC Number: _____

My inmate average monthly account balance is \$ _____

INCOME FROM OTHER SOURCES

Information which may affect my monthly income status. Check all that apply.

<u>SOURCE</u>	<u>MONTHLY AMOUNT</u>	<u>EFFECTIVE DATE</u>
Maintenance (Spousal Support)	\$ _____	
Interest, Dividends	\$ _____	
Pension Income (Retirement)	\$ _____	
Rental Income	\$ _____	
Social Security Disability	\$ _____	
Social Security Retirement	\$ _____	
Social Security Survivors	\$ _____	
Supplemental Security Income	\$ _____	
Aid to the Needy and Disabled	\$ _____	
Public Assistance (TANF)	\$ _____	
Unemployment Compensation	\$ _____	
Veterans Benefits	\$ _____	
Workers Compensation	\$ _____	
Private Disability Insurance	\$ _____	
Other: _____	\$ _____	

PARENTING TIME

The child(ren) born or adopted of this marriage/relationship reside primarily with _____ me _____ the other parent. Number of overnights with me _____ the other parent _____

DAYCARE

Is/Are the child(ren) born or adopted of this marriage/relationship in daycare while one or both parents work? _____ yes _____ no

The charge for such daycare is \$ _____ per _____ hour _____ week _____ month.

If hourly, the child(ren) are in daycare _____ hours per week.

The average monthly cost for daycare is \$ _____

Work-related daycare expenses are paid by _____ me _____ the other parent _____ both _____ other person.

I personally pay \$ _____ or _____ %
 The other parent pays \$ _____ or _____ %
 Other person pays \$ _____ or _____ %
 Daycare assistance \$ _____ or _____ %

Education related daycare expenses are \$ _____ per hour _____ per week.

Education related daycare expenses are paid by ___ me ___ the other parent ___ both ___ other person.

I personally pay \$ _____ or _____ %
 The other parent pays \$ _____ or _____ %
 Other person pays \$ _____ or _____ %
 Daycare assistance \$ _____ or _____ %

___ Attached is proof of current daycare enrollment.

___ Attached is proof of payment of daycare for the school year and summer months.

___ Attached is a summary of yearly daycare expenses.

HEALTH INSURANCE INFORMATION

Includes: Medical, Dental and Vision

Health insurance ___ is ___ is not maintained for the child(ren) born or adopted of this marriage/relationship.

I pay \$ _____ as a monthly cost to cover only the child(ren) of this action on my health insurance.

Name of Insurance Company: _____

Address: _____

Telephone Number: _____

Group Number: _____

Policy Number: _____

Name(s) of all Individual(s) covered: _____

Effective Date of Coverage: _____

If the child(ren) are not covered the monthly cost to add the child(ren) of this action would be \$ _____.

OTHER DEDUCTIONS

The child(ren) born adopted during this marriage/relationship have uninsured health expenses in excess of \$250.00 per year. ___ yes ___ no

The cost of such expense on a routine basis per single illness or condition is \$ _____ per month.

IF YOU FAIL TO HAVE THIS FORM NOTARIZED AND/OR FAIL TO PROVIDE DOCUMENTATION, YOUR CASE PROCESSING COULD BE DELAYED.

I declare under penalty of perjury that I have completed this affidavit and the statements contained herein are true and correct.

Name Date

Sworn to before me in the County of _____, State of _____, this _____ day of _____, _____.

My Commission expires: _____.

Notary Public

[SEAL]