

GENERAL TESTIMONY

(Instructions should be provided to the petitioner as part of the form.)

THIS FORM CONTAINS SENSITIVE INFORMATION – DO NOT FILE THIS FORM IN A PUBLIC ACCESS FILE

The information on this form may be filed with the petition or pleading and may be disclosed to the parties in the case unless accompanied by a nondisclosure finding/affidavit.

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Personal Information Form for UIFSA § 311 must be attached.

File Stamp

Petitioner: Legal Name (first, middle, last, suffix) **IV-D Case:** TANF
 IV-E Foster Care
 Medicaid Only
 Former Assistance
 Never Assistance

Obligee Obligor

Tribal Affiliation (if applicable)

Respondent: Legal Name (first, middle, last, suffix) **Non-IV-D Case:**

Obligee Obligor

Tribal Affiliation (if applicable)

Responding IV-D Case Identifier: _____

Responding Tribunal Number: _____

NOTE:

Initiating IV-D Case Identifier: _____

Initiating Tribunal Number: _____

Nondisclosure Finding/Affidavit attached

This form sent through EDE

I, _____, declare under penalty of perjury:
Legal Name (first, middle, last, suffix)

I. Personal Information About Obligee: (Obligee caretaker complete section I.E only) See section IX

A. Obligee parent information

| | |
|----|--|
| 1. | Legal name (first, middle, last, suffix): |
| 2. | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other |
| 3. | a. Occupation, trade, or profession: |
| | b. Highest level of education attained: |
| 4. | Current tax filing status: <input type="checkbox"/> Single <input type="checkbox"/> Head of household <input type="checkbox"/> Married filing jointly <input type="checkbox"/> Married filing separately <input type="checkbox"/> Qualifying widow/widower with dependent children <input type="checkbox"/> Unknown |

B. Physical description of the obligee parent: (Attach a recent photo if available.)

| | | | | | | | |
|----|------------|----|---------|----|---------|----|-------------|
| 1. | Race: | 2. | Height: | 3. | Weight: | 4. | Hair color: |
| 5. | Eye color: | | | | | | |

C. Is the obligee parent financially responsible for dependent children other than those of this action (listed in section IV)?

Yes No Unknown (If yes, provide information below if known.)

| | | |
|----|--|-------------------|
| 1. | a. Legal name (first, middle, last, suffix): | b. Year of birth: |
| | c. Relationship: | d. Living with: |
| 2. | a. Legal name (first, middle, last, suffix): | b. Year of birth: |
| | c. Relationship: | d. Living with: |

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I. Personal Information About Obligee (Continued):

| | | |
|----|--|-------------------|
| 3. | a. Legal name (first, middle, last, suffix): | b. Year of birth: |
| | c. Relationship: | d. Living with: |

D. Does the obligee parent have an order to pay support for any child listed in C above? Yes No Unknown
 (If yes, fill out information below, if known, and attach a copy of the order and payment record/proof of payment, if available.)

| | | | | |
|----|------------------------------------|---------------------|--|--|
| 1. | a. Child(ren) name(s): | | | |
| | b. Amount: | c. Frequency: | | |
| | d. State and county/tribe/country: | e. Tribunal number: | | |

| | | | | |
|----|------------------------------------|---------------------|--|--|
| 2. | a. Child(ren) name(s): | | | |
| | b. Amount: | c. Frequency: | | |
| | d. State and county/tribe/country: | e. Tribunal number: | | |

| | | | | |
|----|------------------------------------|---------------------|--|--|
| 3. | a. Child(ren) name(s): | | | |
| | b. Amount: | c. Frequency: | | |
| | d. State and county/tribe/country: | e. Tribunal number: | | |

E. Obligee Caretaker information: (Provide any relevant non-party parent information, including financial information, in section IX.)

| | |
|--|---|
| | 1. Caretaker legal name (first, middle, last, suffix): |
| | 2. Caretaker relationship to child is: _____ <input type="checkbox"/> Has legal custody/guardianship of child |
| | 3. Date child(ren) began residing with caretaker: |

II. Personal Information About Obligor:

See section IX

| | |
|-------------------------|--|
| A. Obligor information: | |
| 1. | Legal name (first, middle, last, suffix): |
| 2. | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other |
| 3. | a. Occupation, trade or profession: |
| | b. Highest level of education attained: |
| 4. | Current tax filing status: <input type="checkbox"/> Single <input type="checkbox"/> Head of household <input type="checkbox"/> Married filing jointly <input type="checkbox"/> Married filing separately |
| | <input type="checkbox"/> Qualifying widow/widower with dependent children <input type="checkbox"/> Unknown |

B. Physical description of the obligor: (Attach a recent photo if available.)

| | | | |
|---------------|------------|------------|----------------|
| 1. Race: | 2. Height: | 3. Weight: | 4. Hair color: |
| 5. Eye color: | | | |

C. Is the obligor financially responsible for dependent children other than those of this action (listed in section IV)?

Yes No Unknown (If yes, provide information below if known.)

| | | |
|----|--|-------------------|
| 1. | a. Legal name (first, middle, last, suffix): | b. Year of birth: |
| | c. Relationship: | d. Living with: |

| | | |
|----|--|-------------------|
| 2. | a. Legal name (first, middle, last, suffix): | b. Year of birth: |
| | c. Relationship: | d. Living with: |

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II. Personal Information About Obligor (Continued):

| | | |
|----|--|-------------------|
| 3. | a. Legal name (first, middle, last, suffix): | b. Year of birth: |
| | c. Relationship: | d. Living with: |

D. Does the obligor have an order to pay support for any child listed in C above? Yes No Unknown
(If yes, fill out information below, if known, and attach a copy of the order and payment record/proof of payment, if available.)

| | | |
|----|------------------------------------|---------------------|
| 1. | a. Child(ren) name(s): | |
| | b. Amount: \$ | c. Frequency: |
| | d. State and county/tribe/country: | e. Tribunal number: |

| | | |
|----|------------------------------------|---------------------|
| 2. | a. Child(ren) name(s): | |
| | b. Amount: \$ | c. Frequency: |
| | d. State and county/tribe/country: | e. Tribunal number: |

| | | |
|----|------------------------------------|---------------------|
| 3. | a. Child(ren) name(s): | |
| | b. Amount: \$ | c. Frequency: |
| | d. State and county/tribe/country: | e. Tribunal number: |

III. Legal Relationship of Parents of Children Listed in Section IV: See section IX

| | | | | |
|----|---|---------|----|----------------------------------|
| A. | <input type="checkbox"/> Never married to each other | | | |
| B. | <input type="checkbox"/> Married on | | in | |
| | | (Date) | | (State and county/tribe/country) |
| C. | <input type="checkbox"/> Married by common law for the period | | in | |
| | | (Dates) | | (State and county/tribe/country) |
| D. | <input type="checkbox"/> Legally separated on | | in | |
| | | (Date) | | (State and county/tribe/country) |
| E. | <input type="checkbox"/> Divorce pending in | | | |
| | | | | (State and county/tribe/country) |
| F. | <input type="checkbox"/> Divorced on | | in | |
| | | (Date) | | (State and county/tribe/country) |
| G. | <input type="checkbox"/> Other | | | |

IV. Dependent Child(ren) in This Action: See section IX

| | | | | |
|----|--|--|---|--|
| A. | 1. Legal name (first, middle, last, suffix): | | 2. Parentage established? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 3. Child care expense per month – Total: \$ _____ State Subsidized: \$ _____ Out of Pocket: \$ _____ | | 4. Support order established? <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Living with petitioner? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 6. Does the child receive benefits from Social Security, VA, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, complete the information below.) _____ \$ _____ per month (Benefit type(s)) Based on claim of _____ Relationship to child: _____ (Name) | | | |
| | 7. Tribal Affiliation <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, basis of tribal affiliation: _____) | | | |

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IV. Dependent Child(ren) in This Action (Continued):

| | | | |
|--|--|---|--|
| 1. Legal name (first, middle, last, suffix): _____ | | 2. Parentage established? [] Yes [] No | |
| 3. Child care expense per month – Total: \$ _____ State Subsidized: \$ _____ Out of Pocket: \$ _____ | | 4. Support order established? [] Yes [] No | 5. Living with petitioner? [] Yes [] No |
| 6. Does the child receive benefits from Social Security, VA, etc.? [] Yes [] No (If yes, complete the information below.) _____ \$ _____ per month (Benefit type(s)) Based on claim of _____ Relationship to child: _____ (Name) | | | |
| 7. Tribal Affiliation [] Yes [] No (If yes, basis of tribal affiliation: _____) | | | |

| | | | |
|--|--|---|--|
| 1. Legal name (first, middle, last, suffix): _____ | | 2. Parentage established? [] Yes [] No | |
| 3. Child care expense per month – Total: \$ _____ State Subsidized: \$ _____ Out of Pocket: \$ _____ | | 4. Support order established? [] Yes [] No | 5. Living with petitioner? [] Yes [] No |
| 6. Does the child receive benefits from Social Security, VA, etc.? [] Yes [] No (If yes, complete the information below.) _____ \$ _____ per month (Benefit type(s)) Based on claim of _____ Relationship to child: _____ (Name) | | | |
| 7. Tribal Affiliation [] Yes [] No (If yes, basis of tribal affiliation: _____) | | | |

V. Health Care Coverage: [] See section IX

| | |
|---|--|
| A. Health Care Coverage for Child(ren): For each child listed in section IV, complete the information below. | |
| 1. | a. Child's name: _____ Does this child have health care coverage? [] Yes [] No [] Unknown (If no or unknown, skip to 1.e.) |
| | b. Health care coverage is provided by (check all that apply): [] Medicaid (Skip to 1.e.) [] CHIP (Skip to 1.e.) [] TRICARE (Skip to 1.e.) [] Indian Health Service (Skip to 1.e.) [] Petitioner through an individual policy (Continue to 1.c below.) [] Petitioner through his/her employer (Continue to 1.c below.) [] Respondent through an individual policy (Continue to 1.c below.) [] Respondent through his/her employer (Continue to 1.c below.) [] Other person: _____ Relationship to child: _____ (Complete 1.c below.) |
| | c. Health care coverage provider name: _____ Address: _____ Policy ID number: _____ Group number: _____ |
| | d. Is this a child only policy? [] Yes [] No (If yes, what is the monthly premium for this child only? \$ _____) |
| | e. Who claims a dependency exemption for the child for federal tax purposes? [] Obligee [] Obligor [] Other If other, identify the person: _____ Relationship to child: _____ (Attach a copy of any order addressing the dependency exemption.) |

| | | | |
|--|--|----|---|
| | | f. | Does the individual entitled to claim the dependency exemption change from year to year? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, explain.) _____ |
|--|--|----|---|

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V. Health Care Coverage (Continued):

| | | | | |
|--|--|----|----|---|
| | | 2. | a. | Child's name: _____ |
| | | | | Does this child have health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If no or unknown, skip to 2.e.) |
| | | | | If yes, is all the information the same as Child 1? <input type="checkbox"/> Yes (Skip to 2.e.) <input type="checkbox"/> No (Continue with 2.b.) |
| | | | b. | Health care coverage is provided by (check all that apply): |
| | | | | <input type="checkbox"/> Medicaid (Skip to 2.e.) <input type="checkbox"/> CHIP (Skip to 2.e.) <input type="checkbox"/> TRICARE (Skip to 2.e.) |
| | | | | <input type="checkbox"/> Indian Health Service (Skip to 2.e.) |
| | | | | <input type="checkbox"/> Petitioner through an individual policy (Continue to 2.c below.) |
| | | | | <input type="checkbox"/> Petitioner through his/her employer (Continue to 2.c below.) |
| | | | | <input type="checkbox"/> Respondent through an individual policy (Continue to 2.c below.) |
| | | | | <input type="checkbox"/> Respondent through his/her employer (Continue to 2.c below.) |
| | | | | <input type="checkbox"/> Other person: _____ Relationship to child: _____ (Complete 2.c below.) |
| | | | c. | Health care coverage provider name: _____ |
| | | | | Address: _____ |
| | | | | Policy ID number: _____ Group number: _____ |
| | | | d. | Is this a child only policy? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, what is the monthly premium for this child only? \$ _____) |
| | | | e. | Who claims a dependency exemption for the child for federal tax purposes? <input type="checkbox"/> Obligee <input type="checkbox"/> Obligor <input type="checkbox"/> Other |
| | | | | If other, identify the person: _____ Relationship to child: _____ |
| | | | | (Attach a copy of any order addressing the dependency exemption.) |
| | | | f. | Does the individual entitled to claim the dependency exemption change from year to year? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, explain in section IX.) _____ |
| | | | | |
| | | | 3. | a. |
| | | | | Child's name: _____ |
| | | | | Does this child have health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If no or unknown, skip to 3.e.) |
| | | | | If yes, is all the information the same as Child 1? <input type="checkbox"/> Yes (Skip to 3.e.) <input type="checkbox"/> No (Continue with 3.b.) |
| | | | b. | Health care coverage is provided by (check all that apply): |
| | | | | <input type="checkbox"/> Medicaid (Skip to 3.e.) <input type="checkbox"/> CHIP (Skip to 3.e.) <input type="checkbox"/> TRICARE (Skip to 3.e.) |
| | | | | <input type="checkbox"/> Indian Health Service (Skip to 3.e.) |
| | | | | <input type="checkbox"/> Petitioner through an individual policy (Continue to 3.c below.) |
| | | | | <input type="checkbox"/> Petitioner through his/her employer (Continue to 3.c below.) |
| | | | | <input type="checkbox"/> Respondent through an individual policy (Continue to 3.c below.) |
| | | | | <input type="checkbox"/> Respondent through his/her employer (Continue to 3.c below.) |
| | | | | <input type="checkbox"/> Other person: _____ Relationship to child: _____ (Complete 3.c below.) |
| | | | c. | Health care coverage provider name: _____ |
| | | | | Address: _____ |
| | | | | Policy ID number: _____ Group number: _____ |
| | | | d. | Is this a child only policy? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, what is the monthly premium for this child only? \$ _____) |
| | | | e. | Who claims a dependency exemption for the child for federal tax purposes? <input type="checkbox"/> Obligee <input type="checkbox"/> Obligor <input type="checkbox"/> Other |
| | | | | If other, identify the person: _____ Relationship to child: _____ |
| | | | | (Attach a copy of any order addressing the dependency exemption.) |

| | | |
|--|----|---|
| | f. | Does the individual entitled to claim the dependency exemption change from year to year? |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, explain in section IX.) |

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| | | | | | | | | | | | |
|---|---|---|------------------------------|-----------------------------|---|---------------------------------|--|--|--|--|--|
| V. Health Care Coverage (Continued): | | | | | | | | | | | |
| B. | Health Care Coverage for Petitioner: Does the petitioner have health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to B.4.) | | | | | | | | | | |
| 1. | Petitioner's health care coverage is provided by: <input type="checkbox"/> Medicaid (Skip to B.4.) <input type="checkbox"/> TRICARE (Skip to C.) | | | | | | | | | | |
| | <input type="checkbox"/> Indian Health Service (Skip to C.) | | | | | | | | | | |
| | <input type="checkbox"/> Self through his/her employer (Continue to B.2 below.) | | | | | | | | | | |
| | <input type="checkbox"/> Self through an individual policy (Continue to B.2 below.) | | | | | | | | | | |
| | <input type="checkbox"/> Other person: _____ Relationship to petitioner: _____ (Complete B.2 below.) | | | | | | | | | | |
| 2. | Health care coverage provider name: _____ | | | | | | | | | | |
| | Address: _____ | | | | | | | | | | |
| | Policy ID number: _____ | | | | | Group number: _____ | | | | | |
| | Monthly premium \$ _____ | | | | Portion for the child(ren) listed in section IV: \$ _____ | | | | | | |
| 3. | Other than children of this action listed in section IV, are other adults and/or child(ren) included in this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| | (If yes, provide information below.) | | | | | | | | | | |
| | Total number of adults: _____ | | | | | Total number of children: _____ | | | | | |
| 4. | If the petitioner does not have health care coverage or the coverage is through Medicaid, is employer-sponsored coverage available for: | | | | | | | | | | |
| | a. | Self | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | | | |
| | b. | Child(ren) listed in section IV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | (If no, skip to C.) | | | | | | |
| 5. | Based on the residence of the child(ren), is the petitioner's employer-sponsored coverage accessible to the child(ren) in section IV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If no, skip to C.) | | | | | | | | | | |
| 6. | How much would the premiums be for an insurance plan offered by the petitioner's employer? | | | | | | | | | | |
| | a. | For self: \$ _____ per _____ (weekly, bi-weekly, semi-monthly, monthly, quarterly, yearly) | | | | | | | | | |
| | b. | To add child(ren) in section IV: \$ _____ per _____ (weekly, bi-weekly, semi-monthly, monthly, quarterly, yearly) | | | | | | | | | |
| C. | Health Care Coverage for Respondent: Does the respondent have health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to C.4.) | | | | | | | | | | |
| | <input type="checkbox"/> Unknown (If unknown, skip to D.) | | | | | | | | | | |
| 1. | Respondent's health care coverage is provided by: <input type="checkbox"/> Medicaid (Skip to C.4.) <input type="checkbox"/> TRICARE (Skip to D.) | | | | | | | | | | |
| | <input type="checkbox"/> Indian Health Service (Skip to D.) <input type="checkbox"/> Unknown (Skip to D.) | | | | | | | | | | |
| | <input type="checkbox"/> Self through his/her employer (Continue to C.2 below.) | | | | | | | | | | |
| | <input type="checkbox"/> Self through an individual policy (Continue to C.2 below.) | | | | | | | | | | |
| | <input type="checkbox"/> Other person: _____ Relationship to respondent: _____ (Complete C.2 below.) | | | | | | | | | | |
| 2. | Health care coverage provider name: _____ | | | | | | | | | | |
| | Address: _____ | | | | | | | | | | |
| | Policy ID number: _____ | | | | | Group number: _____ | | | | | |
| | Monthly premium \$ _____ | | | | Portion for the child(ren) in section IV: \$ _____ | | | | | | |
| 3. | Other than children listed in section IV, are other adults and/or child(ren) included in this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| | (If yes, provide information below.) | | | | | | | | | | |
| | Total number of adults: _____ | | | | | Total number of children: _____ | | | | | |
| 4. | If the respondent does not have health care coverage or the coverage is through Medicaid, is employer-sponsored coverage | | | | | | | | | | |

| | | | | |
|----|--|------------------------------|-----------------------------|--|
| | available for: | | | |
| | a. Self | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown (If no or unknown, skip to question D.) |
| | b. Children listed in section IV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown (If no or unknown, skip to question D.) |
| 5. | Based on the residence of the child(ren), is the respondent's employer-sponsored coverage accessible to the child(ren) in section IV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If no, skip to question D.) | | | |

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| | | | | |
|---|---|----------|------------------|---|
| V. Health Care Coverage (Continued): | | | | |
| 6. | How much would the premiums be for an insurance plan offered by the respondent's employer? | | | |
| | a. For self: | \$ _____ | per _____ | (weekly, bi-weekly, semi-monthly, monthly, quarterly, yearly) |
| | b. To add child(ren) in section IV: | \$ _____ | per _____ | (weekly, bi-weekly, semi-monthly, monthly, quarterly, yearly) |
| D. | Do any of the children listed in section IV have special needs or extraordinary medical expenses not covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If yes, provide additional information about the child(ren) involved, the type of needs/medical expenses, and the related costs in section IX.) | | | |
| E. | Is the petitioner asking to be reimbursed for medical expenses paid? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide information below.) | | | |
| | Balance: | \$ _____ | as of _____ | (date) (Provide date, type of expense, and cost in section IX.) |
| F. | Is the petitioner asking to be compensated for ongoing medical expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide information below.) | | | |
| | Type of expense: | _____ | Amount: \$ _____ | per _____ (frequency) |
| | (Provide additional information about the child(ren) involved, the need for ongoing expenses, and the expenses in section IX.) | | | |

| | | | | |
|--|--|--------------------------------|-----------------------------|--|
| VI. Additional Information for Child Support Calculation: | | | | <input type="checkbox"/> See section IX |
| A. | Establishment (If no child support order exists, complete the following section.): | | | |
| 1. | Does a custody/parenting time order exist? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | (If yes, complete the information below and attach a copy of the order.) |
| | | Issuing tribunal number: _____ | Date of order: _____ | |
| 2. | If an order does not exist, is there a written custody/parenting time agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, attach a copy.) | | | |
| 3. | In the past 12 months or since separation (whichever is shorter), how many overnights has the child(ren) stayed with obligee _____ obligor _____? | | | |

4. Is child support sought for a period of time prior to the date of the petition for support (Uniform Support Petition)? Yes No (If yes, complete the following questions and section VIII for the period of time.)

| | | | | |
|----|--|---------------|------------------|-----------------|
| a. | Support is sought from the following date: _____ | | | |
| b. | During the period of time for which retroactive support is being sought, did the child(ren) reside with the obligor, other than the time specified under an existing custody/parenting time order? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, describe.) _____ | | | |
| c. | During the period of time for which retroactive support is being sought, did the obligor make direct payments to the obligee? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, attach an affidavit of payments.) | | | |
| d. | Was public assistance paid for any of the children listed in section IV? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, check the appropriate box and provide the period of benefit and the state.) | | | |
| | <input type="checkbox"/> TANF | _____ / _____ | To _____ / _____ | By: _____ State |
| | | First month | year | Last month |
| | <input type="checkbox"/> Medicaid | _____ / _____ | To _____ / _____ | By: _____ State |
| | | First month | year | Last month |
| | <input type="checkbox"/> Foster Care | _____ / _____ | To _____ / _____ | By: _____ State |
| | | First month | year | Last month |

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VI. Additional Information for Child Support Calculation (Continued):

B. **Modification** (If a child support order exists that the petitioner seeks to modify, complete the following section.):

1. Indicate the basis for the modification petition (check all that apply):

a. The earnings of the obligor have:

substantially increased

substantially decreased

b. The earnings of the obligee have:

substantially increased

substantially decreased

c. The needs of the child(ren) have:

substantially increased

substantially decreased

d. The current support order was most recently established or modified at least 3 years ago or such lesser time as permitted by the laws of the responding jurisdiction.

e. Other; explain: _____

2. Does a custody/parenting time order exist? Yes No (If yes, attach a copy of the order.)

Issuing tribunal number _____ Date of order _____

3. If a custody/parenting time order does not exist, is there a written custody/parenting time agreement? Yes No (If yes, attach a copy of the agreement.)

4. In the past 12 months or since separation (whichever is shorter), how many overnights has the child(ren) stayed with the obligee _____ obligor _____?

VII. Support Order and Payment:

See section IX

A. Is there an order for divorce or legal separation involving the children in this action?

Yes No (If yes, provide a copy of the order.)

B. Does a current support order exist? Yes No (If yes, attach obligor's support payment history.)

C. Does the support order require the obligor to pay amounts to anyone other than to the State Disbursement Unit (SDU) (e.g., directly to the obligee, child care provider, or health care provider)?

Yes No (If yes, complete D.)

D. Has the obligor made any direct payments under the order noted in C?

Yes No (If yes, attach an affidavit of payments.)

E. If a support order does not exist, has the obligor made any voluntary support payments?

Yes No (If yes, attach an affidavit of payments.)

VIII. Financial Information:

See section IX

Information required varies based on responding jurisdiction's support guidelines. Petitioner includes an obligee caretaker with legal custody of the child(ren).

Monthly income from all sources:

1. Is the petitioner employed? Yes; occupation: _____ No; income source: _____

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VIII. Financial Information (Continued):

Monthly income from all sources (Continued):

| | | | |
|----|---|----|-------------------|
| 2. | Gross monthly income amounts: | | <u>Petitioner</u> |
| | a) Public Assistance | | |
| | i) Supplemental Security Income (SSI) | \$ | _____ |
| | ii) TANF | \$ | _____ |
| | iii) Other | \$ | _____ |
| | b) Base pay salary, wages | \$ | _____ |
| | c) Overtime, commission, tips, bonuses, part time | \$ | _____ |
| | d) Unemployment compensation | \$ | _____ |
| | e) Worker's compensation | \$ | _____ |
| | f) Social Security Disability (not SSI) | \$ | _____ |
| | g) Social Security Retirement | \$ | _____ |
| | h) Dividends and interest | \$ | _____ |
| | i) Trust/annuity income | \$ | _____ |
| | j) Pensions, retirement | \$ | _____ |
| | k) Child support | \$ | _____ |
| | l) Spousal support/alimony | \$ | _____ |
| | m) Income producing assets | \$ | _____ |
| | n) All other sources (specify) | \$ | _____ |

| | | | |
|----|----------------------------|----|-------|
| 3. | Deductions from gross pay: | | |
| | a) Federal income tax | \$ | _____ |
| | b) State income tax | \$ | _____ |
| | c) Local tax | \$ | _____ |
| | d) FICA | \$ | _____ |
| 4. | Other deductions: | | |
| | a) Mandatory retirement | \$ | _____ |
| | b) Nonmandatory retirement | \$ | _____ |
| | c) Medical insurance | \$ | _____ |
| | d) Union dues | \$ | _____ |
| | e) Other (specify) | \$ | _____ |

| | | | |
|----|--------------------------|--|----|
| 5. | Gross income prior year: | | \$ |
|----|--------------------------|--|----|

IX. Other Pertinent Information:

GENERAL TESTIMONY, PAGE 10

X. Attached and Incorporated by Reference:

- [] Required number of copies of all support orders for the case
- [] Certified child support payment records
- [] Arrears balance and/or accrued Interest (affidavit of arrears)
- [] Payment history
- [] Copies of three most recent pay stubs from current employer(s)
- [] Copies of unreimbursed medical bills for the child(ren) in this action
- [] Copy of most recent federal tax return
- [] Declaration in Support of Establishing Parentage for each child whose parentage is at issue
- [] Copy of child(ren)'s birth certificate(s)/record(s)
- [] Acknowledgment of parentage
- [] Documentation of legal custody/guardianship of child(ren)
- [] Documentation of child care expenses
- [] Documentation of ongoing medical expenses for the child(ren) in this action
- [] Documentation in support of request for modification
- [] Copy of order for divorce or legal separation involving the child(ren) in this action
- [] Other: _____

[] Additional attached document(s), incorporated by reference.

XI. Declaration:

Under penalty of perjury, all information and facts stated in this General Testimony are true to the best of my knowledge, information, and belief.

| | | |
|------|-------------------------|-----------|
| Date | Petitioner (Name) or | Signature |
|------|-------------------------|-----------|

| | | |
|------|---|-----------|
| Date | Name/Title, Agency or Tribunal Representative | Signature |
|------|---|-----------|

Encryption Requirements:

When communicating this form through electronic transmission, precautions must be taken to ensure the security of the data. Child support agencies are encouraged to use the electronic applications provided by the federal Office of Child Support Enforcement. Other electronic means, such as encrypted attachments to e-mails may be used if the encryption method is compliant with Federal Information Processing Standard (FIPS) Publication 140-2 (FIPS PUB 140-2).