

(INCOME, DEDUCTIONS AND MEDICAL/DENTAL INSURANCE)

Attach copies of recent: (1) federal and state income tax returns; (2) last four pay stubs; and (3) if self-employed, most recent Profit and Loss Statement.

16. YOUR MONTHLY GROSS INCOME:

A. From employment: If paid weekly, multiply income by 4.3 to arrive at a monthly gross income and insert below. If paid every two weeks, multiply two weeks' income by 2.15 and insert below:

Description	Monthly amount
Gross hourly wage:	\$
Average number of hours worked per week:	
Gross monthly income:	\$
Gross monthly tips/commissions/bonuses (identify)	\$
Subtotal: 16.A	\$

B. From Self-employment: If you own an interest in a partnership or in a closely-held corporation, attach last year's Schedule K-1 and/or corporation federal income tax return.

Description	Monthly amount
Gross receipts	\$
Expense reimbursements	\$
Rental income	\$
Royalty income	\$
Less ordinary/necessary expenses	\$
Plus monthly portion of accelerated component of any depreciation allowance or investment tax credits	\$
Subtotal: 16.B	\$0

C. Other sources of income: (Please attach verification of any income available to you as listed below):

Description	Monthly amount
Dividends	\$
Interest income	\$
Trust income	\$
Contract payments (less underlying debt)	\$
Annuity income	\$
Retirement benefits - Pension/IRA/Keogh (non-Social Security benefits)	\$
Social Security income	\$
Workers Compensation benefits per week, multiplied by 4.3 = (per month)	\$
Disability income	\$
Gifts or prizes	\$
Spousal support	\$
Expense reimbursement and/or per diem allowance (not listed in Item B above)	\$
ADC benefits	\$
FCAS (food stamps)	\$
Other (specify)	\$

Subtotal: 16.C \$

D. Summary of your gross income:

Description	Monthly amount
Income from employment (Item 16.A above)	\$
Self-employment income (Item 16.B above)	\$
Other income (Item 16.C above)	\$
YOUR TOTAL MONTHLY GROSS INCOME: 16.D	\$
(Enter here and on the Uniform Support Affidavit, Page 2, line 9.A)	

17. YOUR MONTHLY DEDUCTIONS FROM GROSS INCOME:

A. Mandatory deductions:

Number of exemptions claimed by you:

State income taxes	\$
Federal income taxes	\$
Social Security (FICA)	\$
Workers Compensation insurance premium	\$
Medicare	\$
Wage withholding, wage assignment or garnishment (paid to: _____)	\$
Medical insurance for the parties' joint children if additional premium: total premium _____ less cost of coverage for yourself + other dependents =	\$

Subtotal of Mandatory: 17.A \$

B. Optional deductions:

Description	Monthly amount
Retirement/profit sharing	\$
Savings plan	\$
Credit Union	\$
Other	
Dental	\$
Medical	\$
Tri-met pass	\$
Food benefit	\$
Disability	\$

Subtotal of Mandatory: 17.B \$

C. Summary of deductions:

Mandatory - from Item 17.A above \$
Optional - from Item 17.B above \$

TOTAL MONTHLY DEDUCTIONS: 17.C \$

18. INFORMATION FOR MEDICAL AND DENTAL INSURANCE COVERAGE: (For children listed on Page 1, Item 6 of this schedule which is presently provided or available for the benefit of these children):

_____ I provide this (complete information below)

_____ Other parent provides this (complete, if known)

Health insurance

Dental insurance

Name of insurance company

Plan or Group name

Plan/Group number

Individual ID number

Address for claim submission

Phone number for information

Amount of annual deductible

Gross monthly premium actually paid by you
(exclude amounts paid by your employer)

Monthly premium to cover only you See above

Dependent's portion of monthly premium

Are there dependents other than children on Page 1,
Item 6 of this schedule, enrolled with plan? _____

If "Yes" enter total number of other dependents: _____

I hereby certify that my answers and the information on this affidavit and the attached schedules are true to the best of my knowledge and ability. I further certify that the information on the attached documents is true to the best of my knowledge and ability.

DATED this _____ day of _____, 200_

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 200_

Notary Public for Oregon
My Commission expires:

SCHEDULE 1
(MONTHLY EXPENSES AND REBUTTING FACTORS)

You MUST complete this schedule; however, this schedule is to be considered only if either party intends to rebut the presumptive child support order. These are the total household expenses you must pay each month. Utility bills should be averaged over the year. Any other annual, quarterly or other periodic payments should be converted to a monthly average. **DO NOT LIST ANY EXPENSE IF IT IS DEDUCTED FROM YOUR WAGES. INCLUDE ONLY DIRECT EXPENSES FOR JOINT CHILDREN IN SECTION 1.**

1. Direct MONTHLY expenses for CHILDREN OF THIS RELATIONSHIP which you pay:

	Amount		Amount
A. School expenses: lunches, books, tuition	\$	H. Babysitting (not work related)	\$
B. Food (other than school lunches)	\$	I. Lessons	\$
C. Day care	\$	J. Grooming needs	\$
D. Clothing	\$	K. Hobbies, recreation	\$
E. Medical insurance - premium payments	\$	L. Entertainment	\$
F. Unreimbursed health costs	\$	M. Allowances	\$
G. Unreimbursed dental costs	\$	N. Transportation, gas, oil	\$
		O. Miscellaneous (specify)	
		◇ \$	

TOTAL DIRECT EXPENSES OF CHILDREN: (Add 1.A through 1.O) 1 \$
(Enter here and on Uniform Support Affidavit, Page 2, line 9.B)

Average monthly amount of child's income:

Source	Amount	Name	
2. FIXED COSTS:			
A. RESIDENCE:			
Mortgage or rent	\$	D. INSURANCE:	
Property taxes (if not included in mortgage)	\$	Life	\$
Second mortgage	\$	Automobile	\$
Other	\$	Medical/Dental	\$
B. UTILITIES:		E. FOOD/HOUSEHOLD	\$
Electricity	\$	(exclude food expenses for	
Heat (other than electricity)	\$	joint part 1 above)	
Water	\$	F. CLOTHING	\$
Garbage	\$	Grooming/personal needs	\$
Telephone	\$	G. MEDICINE/PHARMACY	\$
Other	\$	Unreimbursed medical/dental	
C. TRANSPORTATION		costs	\$
Car payments	\$	H. COURT/DNR-ORDERED	
Gas and oil	\$	SUPPORT PAYMENTS	\$
Maintenance/repairs	\$		
Other (specify)	\$		
		TOTAL FIXED COSTS:	2 \$

3. CONSUMER OBLIGATIONS:

Name of creditor	Balance due	Monthly payment
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TOTAL MONTHLY PAYMENTS ON CONSUMER OBLIGATIONS 3 \$

4. DISCRETIONARY EXPENSES:

A. Entertainment	\$	D. Religious contributions	\$
B. Vacations	\$	E. Dues and subscriptions	\$
C. Gifts	\$	F. Club membership/dues	\$

TOTAL DISCRETIONARY EXPENSES 4 \$

5. ADDITIONAL EXPENSES:

\$

\$

TOTAL ADDITIONAL EXPENSES 5 \$

6. **TOTAL EXPENSES EXCLUDING DIRECT EXPENSES OF CHILD:** 6 \$

7. Other factors that affect my income and expenses or that should be considered to rebut the presumptive child support calculations:
(attach supporting documentation whenever possible).