STATE OF NORTH DAKOTA

COUNTY OF _____

IN DISTRICT COURT

_____ JUDICIAL DISTRICT

_____
Plaintiff,

vs

_____
Defendant.

Case No. _____

FINANCIAL AFFIDAVIT
(Parties Agree to All Modifications)

(*This affidavit is completed by the parent who will be the obligor (the individual paying child support), if the court grants the motion to modify primary residential responsibility.*

This affidavit will help you present detailed information to the court to verify the income used to calculate the correct amount of child support based on the North Dakota Child Support Guidelines. You may wish to complete this affidavit at the same time you complete the child support calculator.

Please complete this form based on the modifications to primary residential responsibility in your Stipulated Agreement form. If you need more space, please attach additional pages. Additional information can also be added in the Comment section at the end. Attach all requested documents and additional pages and file with your Motion to Modify Primary Residential Responsibility documents.)

1. PERSONAL BACKGROUND

Name: _____ Last 4 digits of SSN: _____

Year of Birth: _____

Address: _____

_____

_____

List the initials and year of birth of your biological or adopted children who will live with you if the motion is granted:

Child's Initials	Year of Birth

List the initials and year of birth of your biological or adopted children who **will not** live with you and the name of the person with whom each child will live, if the motion is granted:

Child's Initials	Year of Birth	Lives With:

If you have an adopted child, is the adoption subsidized? ❑ Yes ❑ No

If yes, name of the individual receiving the subsidy payment (*if you receive the payment, enter your name or if another individual receives the payment, enter his or her name*): _____ and the state (*North Dakota or another state*) providing the payment: _____

Are you currently incarcerated (*physically confined to a prison, jail, or other correctional facility*)? ❑ Yes ❑ No

If yes, name and address of prison, jail, or correctional facility where you are confined:

_____

_____

Prisoner Identification Number: _____

Date that your current period of incarceration began (*do not include any time that you were confined while awaiting trial or sentencing*): _____

Maximum release date: _____

Are you on work release? ❑ Yes ❑ No

If yes, date that work release began: _____ (*Provide the details of your work release employment in Section 5. Do not skip Sections 2 through 4.*)

Have you been released from incarceration within the past six months? ❑ Yes ❑ No

If yes, date of release: _____

Are you **currently** under any medical restrictions that limit your ability to work? ❑ Yes ❑ No

If yes, describe the restrictions (***you must attach copies of medical records that confirm the work restrictions if you want them to be considered***): _____

_____

2. TAX EXEMPTIONS FOR CHILDREN AND CHILD TAX CREDIT

List the initials and year of birth of the children you will claim as exemptions on your federal income tax return, if the motion is granted. If any of these children are not your biological or adopted children, please indicate the relationship (*for example, stepchild*).

Child's Initials	Year of Birth	Relationship:

Will you alternate claiming the exemption for any of your biological or adopted children with the other parent of those children, if the motion is granted? ❑ Yes ❑ No

If yes, list the initials and year of birth of the children for whom the exemption will alternate, if the motion is granted:

Child's Initials	Year of Birth

Are any of your biological or adopted children for whom you will claim an exemption qualifying children for purposes of the child tax credit? ❑ Yes ❑ No

If yes, list the initials and year of birth of the children who are qualifying children for purposes of the child tax credit:

Child's Initials	Year of Birth

3. PARENTING TIME (*VISITATION*)

If the motion is granted, will the amended judgment specify when you have visitation with your children? ❑ Yes ❑ No

If yes, is the number of nights any of your children spend with you:

More than 69 of 90 consecutive nights? ❑ Yes ❑ No

More than an annual total of 164 nights? ❑ Yes ❑ No

If you answered yes to either of the last two questions, please provide the total number of court-ordered visitation nights per child, per year:

Child's Initials	Year of Birth	Total number of visitation nights per year:

4. CHILDREN'S BENEFITS

Do the children in this motion to modify primary residential responsibility receive any governmental or other benefits on your account? (*Examples include dependent's benefits from the Social Security Administration based on your disability or retirement.*) ❑ Yes ❑ No

If yes, list the initials and year of birth of the children, the type of benefit they are receiving, and the monthly amount of such benefit.

Child's Initials	Year of Birth	Type of Benefit:	Monthly Amount

5. EMPLOYMENT

If you are employed, you must attach:

- A copy of your most recent federal income tax return, including copies of all W-2s, 1099s, and schedules.
- A copy of a year-end or final pay stub from each employer who gave you a W-2 form to attach to your most recent federal income tax return.
- For the current year, copies of your most recent pay stubs from all employers to show your year-to-date income from each employer (*this includes your leave and earnings statement, if you are in the military*).

For confidentiality reasons, black out all social security numbers and financial account numbers that appear on the tax forms and pay stubs you are attaching.

Note: If you have more than one employer, answer the questions in this section based on your primary job. Then attach additional pages to provide the same kind of information for each of your other jobs.

Employer Name:_____

Employer Address:_____

Employer City, State, Zip:_____

Date you started working for this employer:_____

Occupation:_____

Brief job description:_____

Hourly	$	per hour		Hours per week
Monthly	$	per month		
Annually	$	per year		

Number of pay periods (*check one*)	
☐	**Weekly**
☐	**24 per year** (*paid twice per month*)
☐	**26 per year** (*paid every two weeks*)
☐	**Monthly**
☐	**Other:**

Overtime:

Did you work any overtime hours during the past 24 months? ❑ Yes ❑ No

If yes, provide the number of overtime (OT) hours worked in each of the past 24 months:

Mo/Yr _____ OT hours _____	Mo/Yr _____ OT hours _____
Mo/Yr _____ OT hours _____	Mo/Yr _____ OT hours _____
Mo/Yr _____ OT hours _____	Mo/Yr _____ OT hours _____
Mo/Yr _____ OT hours _____	Mo/Yr _____ OT hours _____
Mo/Yr _____ OT hours _____	Mo/Yr _____ OT hours _____
Mo/Yr _____ OT hours _____	Mo/Yr _____ OT hours _____
Mo/Yr _____ OT hours _____	Mo/Yr _____ OT hours _____
Mo/Yr _____ OT hours _____	Mo/Yr _____ OT hours _____
Mo/Yr _____ OT hours _____	Mo/Yr _____ OT hours _____
Mo/Yr _____ OT hours _____	Mo/Yr _____ OT hours _____
Mo/Yr _____ OT hours _____	Mo/Yr _____ OT hours _____
Mo/Yr _____ OT hours _____	Mo/Yr _____ OT hours _____

Rate of pay for overtime hours: $_____

Do you expect to continue to have overtime hours during the next 12 months?

❑ Yes ❑ No; because _____

Commission and tips:

Commissions: $_____ per _____

Tips: $_____ per _____

Bonuses:

Did you receive any bonuses during the past three (3) calendar years? ❑ Yes ❑ No

If yes, provide the amount of bonuses received in each of the past three (3) calendar years and the reason for the bonuses:

Year _____ Amount $_____ Reason: _____

Year _____ Amount $_____ Reason: _____

Year _____ Amount $_____ Reason: _____

Do you expect to receive a bonus during the current calendar year?

❑ Yes ❑ No; because _____

Employee benefits:

Describe the benefits provided to you by your employer and the annual value of such benefit (*examples may include paid vacation and sick leave, health insurance, employer retirement contributions, etc.*)

Benefit provided	**Annual value**
	$
	$
	$
	$

In-kind Income:

Describe any in-kind income provided to you by your employer and the annual value of such income. (*In-kind income means you are allowed to use your employer's property or you are being provided with services at no charge or less than the customary charge. Examples include the use of living quarters, and being provided with transportation, groceries, or utilities.*)

In-kind income received	Annual value
	$
	$
	$

Union dues:

$_____ per month

Name of Union: _____

Are union dues required as a condition of employment? ❑ Yes ❑ No

List each professional/occupational license you hold: _____

_____

Annual professional/occupational license fee: $_____

Is this fee paid or reimbursed by your employer? ❑ Yes ❑ No

Is this license required as a condition of employment? ❑ Yes ❑ No

Are you required, **as a condition of employment**, to contribute to a retirement plan?

❑ Yes ❑ No

If yes, monthly amount of required contribution: $_____

Employee Expenses:

Do you have out-of-pocket expenses for special equipment or clothing required as a condition of your employment? ❑ Yes ❑ No

If yes, describe these items, your annual out-of-pocket expenses for them, and the amount, if any, that you are reimbursed for them:

Item	Annual Out of Pocket Expenses	Amount Reimbursed
	$	$
	$	$
	$	$

Do you have out-of-pocket expenses for lodging when you must travel as a condition of your employment? ❑ Yes ❑ No

If yes, are you reimbursed for these lodging expenses? ❑ Yes ❑ No

If no, please provide the number of overnights in the last calendar year: _____

And this year to date: _____

Are you required, as a condition of employment, to use your personal vehicle to drive between work locations (*this does not include driving between your home and your work*)?

❑ Yes ❑ No

If yes, are you reimbursed for these mileage expenses? ❑ Yes ❑ No

If no, please provide the number of these miles driven in the last calendar year: _____

and this current calendar year to date: _____

Note: If you claim any employment-related expenses for special equipment, clothing, lodging, or mileage, you must provide proof of those expenses if you want them to be considered.

Military Service:

Are you currently in the military? ❑ Yes ❑ No

If yes, branch of service: _____

Rank: _____

Years of service: _____

Duty station (*base and state or foreign country*): _____

_____

List any monthly payment and allowances that have not already been included above:

Type of payment or allowance	Monthly amount
	$
	$
	$
	$

6. HEALTH INSURANCE AND MEDICAL EXPENSES

Do you have access to health insurance coverage, including dental or vision coverage, for your children? ❑ Yes ❑ No

If coverage is or would be available, please provide the following information:

Are you currently enrolled in the **health insurance** plan? ❑ Yes ❑ No

If yes, indicate what type of plan you are currently enrolled in:

❑ Single ❑Single + dependent ❑Family

If you are currently enrolled in the plan, please provide the full names of adult persons, including yourself, **and** the initials and birth year of minor children who are covered under the plan and the effective date of coverage:

Adult Full Name	**Effective date**
Child's Initials and Year of Birth	**Effective date**

Name of insurance company: _____

Address of insurance company: _____

_____

Telephone number of insurance company (*if multiple numbers, please provide the "member services" number*): _____

Group number: _____

Policy number: _____

Name of policyholder: _____

If you are not currently eligible for coverage, on what date will you become eligible?

_____

Your cost for **health insurance** is/would be (*complete all options that are/would be available*):

Single plan	$	**per**	
Single + dependent plan	$	**per**	
Family plan	$	**per**	
Child-only plan	$	**per**	

Do you currently have **dental insurance** for your children? ❑ Yes ❑ No

If yes:

Name of insurance company: _____

Group number: _____

Policy number: _____

Cost of coverage: _____

Child's Initials and Year of Birth	Effective date

Your cost for **dental insurance** is/would be (*complete all options that are/would be available*):

Single plan	$	**per**	
Single + dependent plan	$	**per**	
Family plan	$	**per**	
Child-only plan	$	**per**	

Do you currently have **vision insurance** for your children? ❑ Yes ❑ No

If yes:

Name of insurance company: _____

Group number: _____

Policy number: _____

Cost of coverage: _____

Child's Initials and Year of Birth	Effective date

Your cost for **vision insurance** is/would be (*complete all options that are/would be available*):

Single plan	$	**per**	
Single + dependent plan	$	**per**	
Family plan	$	**per**	
Child-only plan	$	**per**	

Annual amount of out-of-pocket medical expenses you pay for the children for whom support is being determined in this child support matter:

Child's Initials	Year of Birth	Annual Amount
		$
		$
		$

Is it reasonably likely that these medical expenses will continue? ❑ Yes ❑ No

If yes, please explain what these expenses are for: _____

_____

Note: You must provide proof of these expenses if you want them to be considered.

7. UNEMPLOYMENT INFORMATION

If you are currently unemployed, please provide the following information about your last employment. Also, you must attach:

- A copy of your most recent federal income tax return, including copies of all W-2s, 1099s, and schedules.
- A copy of your final pay stub from your last employer.
- If you are receiving or have received unemployment compensation, a copy of your benefits award letter or other documentation showing the amount received.

For confidentiality reasons, black out all social security numbers and financial account numbers that appear on the tax forms you are attaching.

Reason for unemployment: _____
Date you became unemployed: _____
Name of last employer: _____
Employer Address: _____
Employer City, State, Zip: _____
Occupation: _____
Brief job description for your last employment: _____

_____

Wages for last employment:

Hourly	$	per hour		Hours per week
Monthly	$	per month		
Annually	$	per year		

(*This space left intentionally blank.*)

Number of pay periods (*check one*)	
☐	**Weekly**
☐	**24 per year** (*paid twice per month*)
☐	**26 per year** (*paid every two weeks*)
☐	**Monthly**
☐	**Other:**

Overtime:

Average number of overtime hours worked per week during the final 36 months of your last employment: _____

Rate of pay for overtime hours: $_____

Commission and tips for last employment:

Commissions: $_____ per _____
Tips: $_____ per _____

Bonuses:

Please provide information about the type and amount of any bonuses you received during the final 36 months of your last employment: _____

_____

_____

Did you receive severance pay when you became unemployed? ❑ Yes ❑ No

If yes, amount received: $_____

Are you now receiving or, within the past 36 months, did you receive unemployment compensation? ❑ Yes ❑ No

If yes, weekly compensation amount: $_____
Date unemployment compensation began: _____
Date unemployment compensation ended/will end: _____

Work History:

Describe other jobs you have had in the past, aside from your last employer:

_____

_____

8. SELF-EMPLOYMENT INCOME

If you are self-employed you must attach:

- Copies of your personal and business federal income tax returns, including all schedules, for the last five years. These include, as applicable, IRS forms 1040, 1065, 1120, and 1120S.
- If you do not have income tax returns, copies of profit and loss statements for the last five years.
- If you are receiving or have received unemployment compensation, a copy of your benefits award letter or other documentation showing the amount received.

For confidentiality reasons, black out all social security numbers and financial account numbers that appear on the tax forms you are attaching.

Note: If you have more than one self-employment activity, answer the questions in this section based on your primary activity. Then attach additional pages to provide the same kind of information for each of your other activities.

	Structure of Business Entity	Percentage
☐	**Sole proprietorship**	
☐	**Partnership; percent ownership interest:**	
☐	**Limited liability company; percent ownership interest:**	
☐	**S Corporation; percent ownership interest**	
☐	**C Corporation; percent ownership interest**	

Name of business entity: _____

Business Address: _____

City/State/Zip: _____

Business telephone number: _____

Taxpayer identification number(s): _____

	Type of Business
☐	**Farming/Ranching**
☐	**Service**
☐	**Retail Sales**
☐	**Wholesale Sales**
☐	**Other** (*please describe*)

Description of business activity (*e.g., type of service provided, type of item(s) sold, etc.*):

_____

_____

_____

_____

How long has this business been in existence? _____ Years _____ Months

Names of household members who work in this business, the wage/salary paid to the household member, and household member's job duties:

Household Member's Name	Wage/Salary	Job Duties

9. OTHER INCOME

If you are receiving worker's compensation, social security payments, veterans' benefits, military retirement payments, railroad retirement board payments, or any other disability or retirement payments, please attach a copy of your benefits award letter or other documentation showing the amount received.

Are you now receiving or did you receive worker's compensation wage replacement payments?

❑ Yes ❑ No

If yes, weekly payment amount: $_____

Date payments began: _____

Date payments ended/will end: _____

Are you receiving social security disability payments (*this does not mean Supplemental Security Income (SSI)*)? ❑ Yes ❑ No

If yes, monthly payment amount: $_____

Date payments began: _____

Are you receiving social security retirement payments? ❑ Yes ❑ No

If yes, monthly payment amount: $_____

Date payments began: _____

Are you receiving social security survivor's payments? ❑ Yes ❑ No

If yes, monthly payment amount: $_____

Date payments began: _____

Are you receiving Supplemental Security Income (SSI) payments? (*Note: SSI payments are not treated as income under the guidelines.*) ❑ Yes ❑ No

Are you receiving veterans' pension or disability benefits? ❑ Yes ❑ No

If yes, monthly payment amount: $_____

Date payments began: _____

If disability benefits, percent disabled: _____%

Are you receiving military retirement payments? ❑ Yes ❑ No

If yes, monthly payment amount: $_____

Date payments began: _____

Are you receiving total and permanent disability payments from the railroad retirement board?

❑ Yes ❑ No

If yes, monthly payment amount: $_____

Date payments began: _____

Are you receiving occupational disability payments from the railroad retirement board?

❑ Yes ❑ No

If yes, monthly payment amount: $_____

Date payments began: _____

Are you receiving retirement payments from the railroad retirement board?

❑ Yes ❑ No

If yes, monthly payment amount: $_____

Date payments began: _____

Are you receiving any other disability, retirement, or pension payments not included above?

❑ Yes ❑ No

If yes, source of payments: _____

Monthly payment amount: $_____

Date payments began: _____

Dividends and interest	**$**	**per**	
Annuities income	**$**	**per**	
Trust income	**$**	**per**	
Currently deferred income	**$**	**per**	
Receipt of previously deferred income	**$**	**per**	
Was this treated as income to you at the time it was deferred? ❑ Yes; amount previously counted: $ ❑ No			
Gifts and prizes (*exceeding $1,000/year*)	**$**	**per**	
Refundable tax credits	**$**		
Gains	**$**		
Describe transaction resulting in gains:			
Spousal support (*alimony*) **payments received**	**$**	**per**	
Rental income	**$**	**per**	
Mineral lease income	**$**	**per**	
Income from royalties	**$**	**per**	
Other (*specify*)	**$**	**per**	

10. COMMENTS

Please use this section to provide any other information that you feel would help the court to understand the situation, or to supplement answers given above, including any factors that affect your ability to work: _____

11. CHECKLIST OF ATTACHED DOCUMENTS

Please put a check mark next to the documents that are attached to this form:

❑ Business and personal federal income tax returns for the last five years (*if self-employed*).
❑ Business profit and loss statements for the last five years (*if self-employed*).
❑ Most recent federal income tax return, including W-2s,1099s, and schedules.
❑ Year-end or final paystub from each employer who gave you a W-2 form.
❑ Year-to-date paystub from each employer for the current year.
❑ Leave and earnings statement for the current year (*if in the military*).
❑ Unemployment compensation benefits award letter.
❑ Worker's compensation benefits award letter.
❑ Social security benefits award letter (*for disability, retirement, or survivor's payments*).
❑ SSI benefits award letter.
❑ Veterans' pension or disability benefits award letter.
❑ Military retirement award letter.
❑ Railroad retirement board benefits award letter.
❑ Proof of expenses for employment-related special equipment, clothing, lodging, or mileage for driving between work locations.
❑ Proof of out-of-pocket medical expenses paid for the children for whom support is being determined in motion to modify primary residential responsibility.
❑ Current medical records confirming any work restrictions.

(*This space left intentionally blank.*)

12. SIGNATURE

I state, under penalty of perjury, that the information contained in, and attached to, this Financial Affidavit, is true and correct to the best of my knowledge.

Dated this _____ day of _____, 20____

_____

(*Signature*)

_____

(*Printed Name*)

_____

(*Address*) (*City, State, Zip Code*) (*Telephone Number*)

STATE OF _____)

COUNTY OF _____)SS

Signed and sworn to before me on _____, 20_____ by _____.

_____

(*Notary Public or Clerk of Court*)

If Notary, my commission expires: _____