You must file these <u>added</u> forms if you are filing one of the following actions in the Holmes County Court of Common Pleas Domestic Relations Division:

- **DIVORCE (with or without children)**
- **DISSOLUTION (with or without children)**
- **ALL POST-DECREE ACTIONS**

New Case Designation Form	This form tells the Court what type of case you are filing and gives your information to the Court
Financial Affidavit for Computation of Child Support and Medical Support (when children involved)	This form gives the Court the information needed to calculate child support and medical support.
Affidavit for Establishment or Review of a Child Support Order	This form is Required by the Holmes County CSEA (Child Support Enforcement Agency) when setting up or reviewing a child support order. It gives them information to help collect the support order.

***Affidavits must be signed in front of a Notary who will administer an Oath**

NOTICE: After you have filed your Complaint for Divorce, you must go to the CSEA with 1. Application for Child Support Services, and 2. Affidavit for establishment or review of a child support order and have a child support calculation completed and then file it with the Clerk of Courts.

INSTRUCTIONS:

- **All forms must either be typed or printed in ink. You must fill out the forms before taking them to the court. The Court staff will not help you complete the forms.**
- **Once you have completed the main packet and these added forms, you will take all the forms (and copies) to the Clerk's office for filing.**

Holmes County Court of Common Pleas
Domestic Relations Division

NEW CASE DESIGNATION FORM

For Official Use Only:
Case No.: _____
SETS No.: _____

Instructions: Pursuant to Local Rules, this form must be completed and submitted with any new cause of action filed with the Holmes County Clerk of Courts. The Social Security Numbers will NOT be public record.

Case Type: _____
(e.g. dissolution, dissolution with children, divorce, divorce with children, parentage, visitation rights, etc.)

Plaintiff Information:			**Defendant Information:**		
First Name:	Middle Initial:		First Name:	Middle Initial:	
Last Name:	Suffix:		Last Name:	Suffix:	
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
SSN:	DOB:		SSN:	DOB:	
Telephone: (if unrepresented)			Telephone: (if unrepresented)		

Plaintiff Attorney Information: ☐Pro Se			**Defendant Attorney Information:** (if known)		
Attorney Name:			Attorney Name:		
Ohio Sup Ct #:	Telephone:		Ohio Sup Ct #:	Telephone:	
Firm Name:			Firm Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:

Child Information:			
1st Child Name:	**DOB:**	**SSN:**	
Address:	**City:**	**State:**	**Zip:**
2nd Child Name:	**DOB:**	**SSN:**	
Address:	**City:**	**State:**	**Zip:**
3rd Child Name:	**DOB:**	**SSN:**	
Address:	**City:**	**State:**	**Zip:**
** If additional space is needed to list children related to these proceedings, attach additional forms.			

_____
Attorney for Plaintiff (or pro se litigant)

IN THE COMMON PLEAS COURT OF HOLMES COUNTY, OHIO
DIVISION OF DOMESTIC RELATIONS

FINANCIAL AFFIDAVIT FOR COMPUTATION OF CHILD SUPPORT AND MEDICAL SUPPORT

_____ CASE NO. _____
Plaintiff/Petitioner (1)
Address: _____
_____
Phone: _____

Attorney: _____ JUDGE ROBERT D. RINFRET
Attorney Address: _____
_____
Attorney Phone: _____

V.

_____ _____
Defendant/Petitioner (2)/Respondent **(Your Name)**
Address: _____
_____ **Date of Prior Decree:** _____
Phone: _____ **(if applicable)**

Attorney: _____
Attorney Address: _____
_____
Attorney Phone: _____

Notes: In accordance with Local Rules of this court, this affidavit must be filed by each party with every case that concerns minor children, regardless of whether child support or medical support will be paid. You will be required to provide proof of income per local rule and O.R.C. 3119.05. You are under a continuing legal duty to file an updated version of this form if you learn of any additional information. **If more space is needed, attach additional page(s).**

I. Information Required for Support Calculation:

A. Minor or Dependent Children in This Case (Include adopted children and any child of the parties who is over 18 and handicapped)

Child's Name	Date of Birth	Male / Female	Age	Residing with

B. Other Minor Children Living in My Household

Child's Name	Date of Birth	Male / Female	Age	Relationship

C. Other Minor Children of Mine, Not Living in My Household

Child's Name	Date of Birth	Male / Female	Age	Residing with

II. Child Support Guideline Adjustment:

	Father (All Figures Per Year)	**Mother** (All Figures Per Year)
Court ordered child support you pay for other child(ren) in another case		
Case Number where support ordered		
Date of initial order		
Court ordered spousal support you pay to a former spouse		
Number of your other dependent children living with you from a different marriage or relationship Is the other parent of any of your other children also in your household? If yes, how many children do you have with the parent who lives with you?	☐ **Yes** ☐ **No** ☐ ☐	☐ **Yes** ☐ **No** ☐ ☐
Court ordered child support you receive for the dependent child(ren) you indicated on the line above (other parent not in home)		
Child care expenses you pay for child(ren) of this case (employment or educational-related)		
Local income taxes paid or rate of tax where you live or work	**$ or %**	**$ or %**
Self-Employment Tax (5.6% of A.G.I.)		
Private health insurance cost to you for your children (family plan cost less individual plan cost)		
Total number of dependents covered by your insurance		
	Father (All Figures Per Year)	**Mother** (All Figures Per Year)
Any non-means tested benefits received by a child subject to this support order due to the death, disability, or retirement of the parent. This includes SSD, or Veteran's benefits		

III. Income [As defined in O.R.C. 3119.01(C)]:

A. Gross Yearly Income from Employment (If not known, please estimate. Put "EST" after each estimated figure.)

	Father	Mother
Gross yearly employment income		
Employer		
Payroll Address		
City, State, Zip		
Number of paychecks per year	☐ 12 ☐ 24 ☐ 26 ☐ 52	☐ 12 ☐ 24 ☐ 26 ☐ 52
Year-to-date Gross Income	Through date of	Through date of
Prior Year's Tax Refund		

B. Annual Overtime, Commissions, Bonuses (If not known, please estimate. Put "EST" after each estimated figure.)

Father			Mother		
Year3 is Most Recent Year	**Base Income**	**Overtime, Commission, Bonuses**	**Year3 is Most Recent Year**	**Base Income**	**Overtime, Commission, Bonuses**
_____ Year 1			**_____ Year 1**		
_____ Year 2			**_____ Year 2**		
_____ Year 3			**_____ Year 3**		
Y-T-D This Year Through:					

D. Gross Self-Employment Income (If not known, please estimate. Put "EST" after each estimated figure.) Use Gross Annual Figures for Most Recent Full Year. See O.R.C. 3119.01(C)

	Father	Mother
Business Receipts		
Ordinary & Necessary Business Expenses		
Net Business Income		

D. Other Income All other income, actual or expected, including pension, social security, workers compensation, commissions, royalties, disability benefits, trust income, annuities, reoccurring capital gains, unemployment benefits, rents, expense-sharing, dividends, interest, AFDC, SSI, food stamps, spousal support received from a prior spouse, etc. (If not known, please estimate. Put "EST" after each estimated figure.)

Father		Mother	
Describe	Per Year	Describe	Per Year

E. Total Annual Income

	Father	Mother
Total Gross Annual Income		
Total average gross monthly income		
Average monthly deductions		
Total net monthly income		

F. Benefits of Employment (Use of company car, country club memberships, stock options, etc.)

Father		Mother	
Benefits	Values	Benefits	Values

IV. Private Health Insurance Information

CHECK ALL APPLICABLE BOXES AND FILL-IN ALL BLANKS.

☐ **My child(ren is/are covered by low-income government –assisted health care coverage (Healthy Start/Medicaid, etc.)**

_____

LIST OF PLANS

I have the following **private health insurance** policies, contracts or plans to cover the child(ren) available to me.

Name of Insurance Company	Entity/group through which policy, contract, or plan is available

NO PRIVATE HEALTH INSURANCE

☐ **I DO NOT HAVE the child(ren) enrolled in private health insurance because:**

☐ health insurance **is not available** through my employer or another group policy, contract or plan that will cover the children.

☐ I **declined enrollment** of the child(ren) in health insurance available through my employer or another group policy, contract or plan, but **I am enrolled in a policy, contract or plan for myself**.

☐ I am not yet eligible to enroll in private health insurance through employment or another group policy, contract or plan, but I will become eligible on (month/day/year) ____/____/_____.

☐ I expect to enroll the child(ren) when I become eligible.

☐ OTHER reason the child(ren) is/are not enrolled (explain):

_____

CURRENT PRIVATE HEALTH INSURANCE ENROLLMENT

☐ **I DO HAVE the child(ren) enrolled in private health insurance through:**

☐ an **individual (non-group)** policy, contract or plan.

☐ a **group** policy, contract or plan.

Date child(ren) was/were enrolled in private health insurance: (month/day/year) ____/____/_____.

Provided through: ☐ Employer ☐ Current Spouse ☐ Other: _____

Name of Policyholder: _____

Insurance Co. Name: _____

Policyholder address: _____

Ins. Co. Claims address _____

_____

_____

Policyholder Phone No. (___) _____

Ins. Co. Claims Phone No. (____) _____

Name of policy, contract or plan _____

Group Number: _____

Identification/subscriber Number: _____

ACCESSIBILITY OF PRIMARY CARE SERVICE

My child(ren) has/have primary care services (health care/laboratory services customarily provided by a general practitioner,
internal medicine, family medicine physician, or pediatrician) **accessible with this private health insurance:**

☐ within **30** miles of the child(ren)'s home.

☐ because the child(ren) **live(s)** in a geographic area where the residents customarily travel farther than 30 miles for their child(ren)'s primary care services.

☐ because primary care services are **only accessible by public transportation.** (Primary care services are accessible by public transportation and the person responsible for taking the child(ren) for primary care service is dependent upon public transportation).

REASONABLENESS OF COST/BEST INTEREST OF CHILDREN CONSIDERATIONS

The cost for private health insurance benefits that cover me and/or my child(ren) or will cover us when I am eligible is: (Do not include the amount than an employer or other person/entity pays for health insurance.)

Single coverage	$_____	per month
Single coverage plus one	$_____	per month
Single coverage plus two	$_____	per month
Family coverage (unlimited dependents)	$_____	per month
Other (explain): _____	$_____	per month

☐ I want to enroll/continue to have the child(ren) enrolled in the private health insurance plan in which I am currently enrolled/will become eligible to enroll in **even if the cost exceeds 5% of my TOTAL ANNUAL GROSS INCOME** (Health Insurance Maximum).

Number of Dependents currently enrolled or who will be enrolled when I become eligible: _____

Name of Dependent	Relationship to You
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

V. List any additional factors or special circumstances you believe the court should consider.

_____
_____
_____
_____

OATH OF AFFIANT

I, _____(print) hereby swear or affirm that the information set forth in this Affidavit of Income, Expenses, and Property above is true, complete, and accurate. *I understand that falsification of this document may result in a contempt of court finding against me which could result in a jail sentence and fine, and that falsification of this document may also subject me to criminal penalties for perjury (O.R.C. 2921.22).*

_____
AFFIANT

Sworn to and subscribed before me this _____ day of _____, _____.

_____
Notary Public

Holmes County Child Support Enforcement Agency
PO Box 72
Millersburg, Ohio 44654
330-674-1111
800-971-7979
Fax: 330-674-0770

AFFIDAVIT FOR ESTABLISHMENT OR REVIEW OF A CHILD SUPPORT ORDER

Respond to each question. If the question does not apply to you, write N/A (not applicable), or if you do not know the answer, write UNK (unknown).

Please print or type legibly

A. Personal Data

Court / CSEA Case number _____

Name _____

Address _____

Home Phone _____

Work Phone _____

Social Security Number _____ Date of Birth ____/____/____

Name of other party: _____

Address & phone number of other party:_____

Date of birth and/or social security number of other party: _____

CHILDREN OF THIS ACTION:

NAMES:	DATES OF BIRTH:
_____	____/____/_____
_____	____/____/_____
_____	____/____/_____

Number of minor children *of this action* living in your home? _____

B. Other Support Obligations

1. Do you have any *other* minor children (NOT including stepchildren) for whom you are required to pay support? If so, please give their names and dates of birth:

   _____

   _____

   If yes, how much do you pay a month? $_____ Arrears amount? $_____

3. Do you pay spousal support to a former or current spouse? _____

How much do you pay? $_____

4. If you are paying child support and/or spousal support on another case, in what County and State was the order issued and what is the court order number?

   County: _____ State: _____ Order Number _____

   **If you have an order in another State, provide a copy of the order.*

5. Number of *other* minor children in your home that were born to you or adopted by you and not a party to this action (DO NOT include step children) _____

   Please provide their names and dates of birth:

   _____

   _____

6. Do you receive support for these children? _____ Amount per month? $_____

C. Income

1. Are you Self Employed? _____

   ** If you answered 'yes' to this question, you MUST provide your tax documents, including a 1099 or Schedule C, showing your income and business expenses.*

2. Name of your present or most recent employer:_____

3. Address of present or most recent employer: _____

4. Employer phone number: _____

5. Dates of employment: _____ to _____

6. How often are/were you paid?
   ☐ weekly ☐ every other week ☐ wice a month ☐ monthly ☐ other

   If "other", please explain: _____

7. What is/was your hourly wage? $_____

8. Number of hours worked per week? _____ Overtime rate? $_____

9. Gross annual income from Employment / Self-Employment:
   **Do not include overtime, bonuses, worker's compensation, or unemployment.*

   Two Years ago $_____ Last Year $_____ This year $_____

10. Overtime and/or Bonuses:

    Two Years ago $_____ Last Year $_____ This year $_____

11. If you have been employed with present employer for less than one year, list previous employer and address:
_____

12. List hourly wage with previous employer: $_____

13. Other Income for current year:

Interest or Dividends:	$_____
Unemployment Compensation	$_____
Workers Compensation:	$_____
Veteran's Benefits:	$_____
Other Pension:	$_____
Alimony:	$_____
Tips:	$_____
Social Security:	$_____
Other	$_____ please specify below

_____

_____

**You must provide documentation of this income, such as approval letter for SSI or SSD, W-2 and tax forms and pay stubs.*

14. Do you receive public assistance? _____ In what County/ State? _____

15. Amount of local income tax paid last year? _____, what City?_____

16. Do you have any medical conditions or disabilities which prohibit you from working?_____

*If yes, what condition? _____

** Must provide medical documentation and an note from your physician which prohibits you from working.*

D. Education / Training:

If a parent is voluntarily unemployed or underemployed, child support may be calculated based on a determination of potential income. It is within the CSEA's discretion to impute income on a case by case basis. If the agency should decide to impute income, a determination will be made of your employment potential and probable earnings level.

1. Name and Location of High School: _____

Highest grade completed _____

2. Name and Location of College, Vocational, Technical, or Trade School:_____
_____

3. Specialized training or skills: _____
_____

4. Degrees obtained: _____

E. Health Insurance:

1. Do you provide health insurance for the child(ren) of this order? _____

2. If yes, what is the annual cost for Family coverage? $ _____

   Annual cost of single coverage? _____

   ** must provide cost of both plans*

3. Is the insurance provided through you or your current spouse? _____

4. Name of your insurance company: _____

   Address: _____

   Plan or Group Number _____

5. If the child(ren) is/are not currently covered by insurance, does you employer provide a health insurance plan? _____

   If yes, what is the annual cost for Family coverage? $ _____

   Annual cost of single coverage? _____

Other:

1. Do you provide childcare for the child(ren) of this action while you are at work, training, or school? ____

   If yes, how much do you pay? $_____

   **Provide proof of childcare expenses for credit.*

2. Do you pay mandatory work related expenses?

   If 'yes', please list: _____

   **Provide documentation of expenses*

I swear or affirm that this information is complete and truthful to the best of my knowledge:

_____ _____

Signature Date

Sworn to before me and subscribed before me this _____day of _____, 20__.

_____

Notary Public

THIS AFFIDAVIT MUST BE NOTARIZED