TUSCARAWAS COUNTY CSEA
154 2ND Street NE
New Philadelphia, OH 44663

Phone: (330) 343-0099
Toll Free: (800) 685-2732
Fax: (330) 364-4854

<RequestingPartyFirst&LastName>
<RPAddress1>
<RPAddress 2>
<RPCity,State,Zip>

Other Party Name: <Name>
Custodial Parent or Caretaker: <Name>
Case Number: <SETS Case No.>
Order Number <Order #>

Date: <Print Date>

FINANCIAL QUESTIONNAIRE

The information requested below is vital for the CSEA to accurately calculate the amount of child support to be paid and to allocate the costs of providing for the health care needs of the children between the parents. Please complete each applicable field clearly, providing the most information you can, including any partial information. Please supply copies of any information requested. If you need additional space to provide complete responses, please attach additional pages.

YOUR INFORMATION		
Last Name	First Name	Middle Initial
Residential Address		Apartment/Unit #
City	State	Zip
Mailing Address		Apartment/Unit #
City	State	Zip
Date of Birth	SSN	Email
Home Phone	Cell Phone	Other Phone(s)
	Are you able to receive text messages? ☐ YES ☐ NO	

LIST THE MINOR CHILD(REN) OF THIS ORDER			
Child 1	SSN	DOB	Does this child primarily reside with you? ☐ YES ☐ NO
Child 2	SSN	DOB	Does this child primarily reside with you? ☐ YES ☐ NO
Child 3	SSN	DOB	Does this child primarily reside with you? ☐ YES ☐ NO
Child 4	SSN	DOB	Does this child primarily reside with you? ☐ YES ☐ NO

DAY CARE COSTS FOR THE CHILDREN OF THIS ORDER

Do you pay day care for children of this order so that you can go to work or school? ☐ YES ☐ NO

Child's name: ____________________________________ Amount $____________________/annually

Child's name: ____________________________________ Amount $____________________/annually

Child's name: ____________________________________ Amount $____________________/annually

Child's name: ____________________________________ Amount $____________________/annually

If you answered yes, you must attach proof of payments in the form of receipts, canceled checks, or notarized statement from the child care provider.

SOCIAL SECURITY BENEFITS FOR THE CHILDREN OF THIS ORDER

Do any of your child(ren) receive Social Security benefits based upon the parent's disability? ☐ YES ☐ NO

Child's name:____________________________ Amount $________/month Due to ☐Mom's disability OR ☐Dad's disability

Child's name:____________________________ Amount $________/month Due to ☐Mom's disability OR ☐Dad's disability

Child's name:____________________________ Amount $________/month Due to ☐Mom's disability OR ☐Dad's disability

Child's name:____________________________ Amount $________/month Due to ☐Mom's disability OR ☐Dad's disability

If you filled out this section, you must attach proof (i.e. an award letter) of the frequency and amount of the monthly benefits.

DO YOU HAVE OTHER NATURAL OR ADOPTED MINOR CHILDREN NOT LISTED ABOVE? ☐ YES ☐ NO

Name	DOB	Does this child live with you? ☐ YES ☐ NO
I ☐ receive ☐ pay $________/month		Case No. ____________________ County ________________
Name	DOB	Does this child live with you? ☐ YES ☐ NO
I ☐ receive ☐ pay $________/month		Case No. ____________________ County ________________
Name	DOB	Does this child live with you? ☐ YES ☐ NO
I ☐ receive ☐ pay $________/month		Case No. ____________________ County ________________
Name	DOB	Does this child live with you? ☐ YES ☐ NO
I ☐ receive ☐ pay $________/month		Case No. ____________________ County ________________

If you filled out this section, you must attach proof with birth certificate(s) or adoption papers.

SPOUSAL SUPPORT

Do you receive Spousal Support? ☐ YES ☐ NO I receive $__________/month County____

Do you pay Spousal Support? ☐ YES ☐ NO I pay $__________/month County____

MILITARY Attach a copy of your Leave and Earnings Statement(LES)

Do you receive pay from the military? ☐YES ☐NO Basic $_____________/mo. BAS $___________/mo. BAH $__________/mo.

Rank ______________________ Branch _____________________________ Years of Service ___________

EMPLOYMENT INFORMATION

Are you employed? ☐YES ☐NO If yes, when did you begin employment? _________________

Employer 1	Address (Payroll address, if different)	Phone
☐Full Time ☐Part Time ☐Seasonal	Paychecks received ☐Weekly ☐Bi-Weekly ☐Monthly ☐Bi-Monthly ☐Other ________	

☐Salary $____________/per month ☐Hourly $________/per hr | Hours Worked Per Week ________________

☐Overtime $__________ Last Year $__________ 2 Years ago $__________ 3 Years ago

☐Bonuses $__________ Last Year $__________ 2 Years ago $__________ 3 Years ago

☐Commission $__________ Last Year $__________ 2 Years ago $__________ 3 Years ago

Do you have a second job? ☐YES ☐NO

Employer 2	Address	Phone
☐Full Time ☐Part Time ☐ Seasonal	Paychecks received ☐Weekly ☐Bi-Weekly ☐Monthly ☐Bi-Monthly ☐Other _____	

☐Salary $______________/per month ☐Hourly $________/per hr | Hours Worked Per Week ________________

☐Overtime $__________ Last Year $__________ 2 Years ago $__________ 3 Years ago

☐Bonuses $__________ Last Year $__________ 2 Years ago $__________ 3 Years ago

☐Commission $__________ Last Year $__________ 2 Years ago $__________ 3 Years ago

ARE YOU SELF EMPLOYED? ☐YES ☐NO **If yes, attach your Schedule C** | Self-employment total gross receipts: $______________________

Name of business: ____

Type of business: ____

Ordinary and necessary business expenses: $__________________

WORK HISTORY

LIST YOUR LAST 3 EMPLOYERS:

Employer Name & Address:
Date of employment: _______ to ________ Last Pay Rate $____________

Employer Name & Address:
Date of employment: _______ to ________ Last Pay Rate $____________

Employer Name & Address:
Date of employment: _______ to ________ Last Pay Rate $____________

My usual occupation is ____ Last grade of school completed_____________________

Degree(s), Certificate(s), or Professional License(s):____

Are you medically disabled? ☐YES ☐NO **If yes, provide proof of disability.**

DO YOU RECEIVE FUNDS FROM THE FOLLOWING SOURCES? Check all that apply and attach verification

☐ I receive $__________ per ______ from pensions or retirement accounts ____(list source)

☐ I receive $__________ per ______ from Supplemental Security Income (SSI)

☐ I receive $__________ per ______ from Social Security Disability Benefits (SSD)

☐ I receive $__________ per ______ from annuities and/or dividends and/or other investment income

☐ I receive $__________ per ______ from rental property

☐ I receive $__________ per ______ from unemployment compensation

☐ I receive $__________ per ______ from Worker's Compensation

☐ I receive $__________ per ______ from ____(list sources)

Do you have a pending claim from an above source? ☐YES ☐NO If yes, list source:____

If you are not employed and do not receive any of the above benefits, please explain how you support yourself.

CITY TAXES AND OTHER MANDATORY DEDUCTIONS Attach a copy of last year's completed tax form

Do you pay local (city) income tax? ☐YES ☐NO If yes, amount $___________ per ____________

Do you pay required union dues/uniform /work expenses? ☐YES ☐NO If yes, amount $___________ per ______________

HEALTH INSURANCE INFORMATION Attach copies of all health insurance cards

Do you currently have health insurance coverage? ☐YES ☐NO If yes, beginning date of coverage______________________

Is this health insurance available through: ☐ Employer ☐Spouse's Employer ☐State (i.e. Medicaid, etc) ☐ Other ___________________

Do the child(ren) have health care coverage? ☐YES ☐NO If no, is health insurance coverage available? ☐YES ☐NO

Is this health insurance available through: ☐ Employer ☐Spouse's Employer ☐State (i.e. Medicaid, etc) ☐ Other ___________________

If coverage is provided or is available through your current spouse, please provide the following information about your spouse:

Spouse's name: ____ Spouse's SSN: ______________________________________

Spouse's address, if different from yours: ____ Spouse's DOB: ________________

List individuals currently covered by available health insurance:

Name ______________________________________ Relationship _________________________________

Name ______________________________________ Relationship _________________________________

Name ______________________________________ Relationship _________________________________

Name ______________________________________ Relationship _________________________________

Name ______________________________________ Relationship __________________________________

Name of health insurance company or union (provide union local number): ____

Address: ____

Phone number: __________________________________ Policy holder name: ____

Policy number: ___________________ Group number: ____________________ Type of insurance (i.e. medical, dental, etc):_________________

Name of additional health insurance company or union (provide union local number):____

Address: ____

Phone number: __________________________________ Policy holder name: ____

Policy number: ___________________ Group number:____________________ Type of insurance (i.e. medical, dental, etc) _________________

Please attach an additional sheet to supply information about any additional health insurance plans that provide coverage for the child(ren). **Please attach copies of all health insurance cards.**

COST OF HEALTH CARE INSURANCE IF AVAILABLE, REGARDLESS OF WHETHER YOU CURRENTLY CARRY IT

Medical	Single coverage cost: $__________/mo.	Single plus dependent cost: $__________/mo.	Family cost: $___________/mo.
Dental	Single coverage cost: $__________/mo	Single plus dependent cost: $__________/mo.	Family cost: $___________/mo.
Vision	Single coverage cost: $__________/mo	Single plus dependent cost: $__________/mo.	Family cost: $___________/mo.

DOCUMENTATION PROVIDED AND SIGNATURE

I have attached the following documentation (check all that apply):

☐ W-2's, IRS 1099, and all other IRS forms and schedules from last year. If self employed, I have attached the previous three year of returns, including all accompanying schedules.

☐ Six months of pay stubs

☐ Disability letter from Workers Compensation or Social Security or a letter from a certified health care provider with my diagnosis and a determination stating how long I will be unable to work

☐ Proof of any other non-employment income

☐ Copies of health insurance cards

☐ Proof of my out-of-pocket costs to provide health insurance for my child(ren)

☐ Proof of my out-of-pocket costs to provide child day care for my child(ren) while I'm at work or school

☐ Proof of the amount of social security received by my child due to my or the other parent's disability or retirement

☐ Proof of children born or adopted by me not of this order (birth certificate, adoption decree)

NOTICE: Failure to provide all information requested could result in the agency making reasonable assumptions regarding your income or filing of a motion for contempt for failure to comply with an administrative order. In addition, your employer could be subpoenaed, requiring them to produce records regarding your income and health care information. If you have any questions, please do not hesitate to contact the <County Name> County CSEA.

___________________________________ ____ ______________

Signature Print Name Date