

**IN THE COURT OF COMMON PLEAS OF MUSKINGUM COUNTY, OHIO**

\_\_\_\_\_  
Plaintiff / Petitioner

Case No.: \_\_\_\_\_

**-vs-/-and-**

**FINANCIAL AFFIDAVIT  
POST-DECREE MOTIONS (DR2)**

\_\_\_\_\_  
Defendant / Petitioner

\_\_\_\_\_  
(Affiant), being duly sworn, says:

<b><u>PART A - CASE INFORMATION</u></b>	
<b>Affiant's Full Name</b>	
Telephone	
Social Security No.	
Date of Birth	
<b>Employer/Source of Income</b>	
Street Address	
City/State/Zip	
Telephone	
Acct./Claim No.	
<b><u>PART B - ANNUAL INCOME</u></b>	
<b>Gross annual wages (excluding overtime and bonuses)</b>	\$
<b>Gross annual unemployment benefits</b>	\$
<b>Gross annual worker's compensation</b>	\$
<b>Gross annual interest or dividends</b>	\$
<b>Other:</b>	\$
<b>Gross annual overtime or bonuses for past three years</b>	
Last year	\$
Two years ago	\$
Three years ago	\$
<b><u>PART C - DEPENDENT INFORMATION</u></b>	
LIST EACH BIOLOGICAL OR ADOPTIVE <u>MINOR</u> CHILD, NOT THE SUBJECT OF THIS ACTION, LIVING WITH YOU AND STATE THE ANNUAL AMOUNT OF CHILD SUPPORT YOU RECEIVE FOR EACH CHILD. <u>DO NOT</u> INCLUDE THE CHILD(REN) INVOLVED IN THIS ACTION, <u>DO NOT</u> INCLUDE STEP-CHILDREN.	
Child's Name	Annual Child Support Received
	\$
	\$
	\$
	\$
	\$

**PART D - EXPENSES**

<b>Annual Child support paid for other child(ren):</b> (Attach certified statement from CSEA)	\$
<b>Annual Sousal support paid for ex-spouse:</b> (Attach certified statement from CSEA)	\$
<b>Annual health insurance permium paid:</b> (Only if child(ren) in this action are covered)	\$
<b>Annual work-related child care expense:</b> (Only for child(ren) in this action)	\$

**PART E - GROUP HEALTH INSURANCE FOR MINOR CHILDREN**

INSTRUCTIONS: ANSWER THE FOLLOWING QUESTIONS ABOUT THE AVAILABILITY, COST, AND COVERAGE OF GROUP HEALTH INSURANCE FOR THE MINOR CHILD(REN) INVOLVED IN THIS ACTION.

<b>Available through your employment (Yes or No):</b>	
<b>Available through non-employer (Yes or No):</b>	
<b>Name and address of insurance Company:</b>	
<b>Group policy number:</b>	
<b>Cost to you PER YEAR:</b> (DO NOT INCLUDE ANY AMOUNT PAID BY THE EMPLOYER.)	\$

Summarize the benefits of each plan (i.e. DEDUCTIBLES, CO-PAYMENTS, HMO, COMPREHENSIVE, MAJOR MEDICAL, DENTAL, OPTICAL, ETC...).

\_\_\_\_\_  
Affiant

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public