

STATE OF VERMONT

SUPERIOR COURT

FAMILY DIVISION

Unit

Docket No.

Empty box for Unit and Docket No.

Table with columns: Plaintiff Name, DOB, V., Defendant Name, DOB

FINANCIAL AFFIDAVIT (400-813A)

I am: [ ] Plaintiff [ ] Defendant [ ] Other: \_\_\_\_\_

Form with fields: Name, Street Address, Mailing Address, Town/City, State, Zip, Phone Number (day), Phone Number (evening), Email Address

INSTRUCTIONS: You are required to complete and file the 813A if-

- 1. You are a party in a newly filed divorce, civil union dissolution, legal separation, annulment or parentage action and you and the other party have minor children; OR
2. You or the other party are seeking to modify a previously issued order regarding child support or spousal maintenance (alimony); OR
3. You are the person required to pay support, and an enforcement action has been filed against you; OR
4. Your child is in the custody of the Department of Children and Families and support has been requested of you; OR
5. You are ordered by the Court to complete and file this form or the other party requests that you fill out the form as part of the discovery process.

DEADLINE FOR FILING: This form must be filed with the court before or at your first case manager's conference. If no conference is scheduled it must be filed at least seven (7) days before your first scheduled court hearing.

YOU MUST SEND A COPY OF YOUR COMPLETED FORM TO THE OTHER PARTY AT THE SAME TIME YOU FILE IT WITH THE COURT.

When you have completed the form and filled in all the required information, you must sign the Affirmation section below and have your signature notarized.

AFFIRMATION

I have read and filled in all the information requested. I hereby affirm of my own knowledge that the facts and financial information I have stated are true and correct as of the date of this Affirmation and that I am not omitting any source or amount of income or other information requested on this form. I understand that any false information may constitute perjury by me. I also understand that if I fail to provide the required information or give misinformation, the judge may order sanctions against me.

Signature of person making affidavit

Sworn to me on

Signature of Notary Public

My Commission Expires:

**SECTION I – INCOME**

EMPLOYER NAME and ADDRESS	SECOND EMPLOYER

- I am self-employed (sole proprietor, partnership, d/b/a) as a \_\_\_\_\_
- I am not currently employed because \_\_\_\_\_

**A. MONTHLY GROSS INCOME FROM EMPLOYMENT** - Income before any deductions for payroll taxes or benefits. (If your income varies throughout the year, calculate your annual income and divide by twelve to get your monthly income in each category below.)

**To calculate MONTHLY amounts from paychecks:**

- If you are paid weekly, multiply average weekly pay by 4.333.
- If you are paid every other week, multiply average bi-weekly pay by 2.165
- If you are paid twice a month, multiply average semi-monthly pay by 2

**ATTACH 4 MOST RECENT PAY CHECK STUBS.**

1. SALARY OR WAGES \_\_\_\_\_  
I have included overtime     Yes                       No
2. TIPS, COMMISSIONS, BONUSSES, ROYALTIES \_\_\_\_\_
3. SELF EMPLOYMENT INCOME \_\_\_\_\_  
(Complete Self Employment Attachment on page 11 or attach IRS SCHEDULE C from tax filing)
4. PERSONAL EXPENSES PAID BY EMPLOYER \_\_\_\_\_  
(for example: cell phone, car, housing allowance, meals, military allowances)

Total Income from Employment \_\_\_\_\_

**B. OTHER SOURCES OF INCOME (Indicate Monthly Amount)**

1. RENTAL INCOME \_\_\_\_\_  
(Complete Rental Income Attachment on page 10 or attach IRS SCHEDULE E from tax filing)
2. RETIREMENT/PENSIONS \_\_\_\_\_
3. UNEMPLOYMENT INSURANCE BENEFITS \_\_\_\_\_
4. WORKER'S COMPENSATION and/or DISABILITY INSURANCE \_\_\_\_\_
5. SOCIAL SECURITY BENEFITS (Specify type \_\_\_\_\_) \_\_\_\_\_
6. VETERANS BENEFITS (VA) \_\_\_\_\_
7. INTEREST OR DIVIDEND INCOME \_\_\_\_\_
8. TRUST OR ANNUITY INCOME \_\_\_\_\_
9. GIFTS OR PRIZE MONEY (Including lottery winnings) \_\_\_\_\_
10. SPOUSAL MAINTENANCE (Alimony) \_\_\_\_\_  
(From the other party in this action)
11. SPOUSAL MAINTENANCE (Alimony) \_\_\_\_\_  
(From a person not a party in this action)
12. OTHER: Please specify \_\_\_\_\_  
(For example, capital gains)

Total Income from Other Sources \_\_\_\_\_

**TOTAL MONTHLY INCOME**  
\_\_\_\_\_ (Employment and Other Sources)

**SECTION II - PUBLIC BENEFITS**

**DO YOU RECEIVE PUBLIC BENEFITS?**

Yes       No

**If yes, please check all boxes that apply and indicate dollar amount, where applicable**

- Reach Up, RUFA, TANF \_\_\_\_\_
- Dr. Dynasaur/Blue First \_\_\_\_\_
- Fuel Assistance \_\_\_\_\_

- General Assistance \_\_\_\_\_
- Medicaid/Medicare \_\_\_\_\_
- Food Stamps \_\_\_\_\_

- SSI \_\_\_\_\_
- VHAP \_\_\_\_\_
- Housing Assistance \_\_\_\_\_

**SECTION III - INCOME/EXPENSES of MINOR CHILDREN**

*"Minor Children" means children under 18 or children over the age of 18 but still in high school.*

**A. LIST ALL MINOR CHILDREN YOU HAVE WITH THE OTHER PARTY**

NAME	Date of Birth	Current Primary Residence

**B. LIST ALL OTHER MINOR CHILDREN FOR WHOM YOU PROVIDE SUPPORT**

NAME	Date of Birth	Relationship to you	Current Primary Residence

**C. LIST ALL CHILDREN FOR WHOM YOU ARE ORDERED TO PAY CHILD SUPPORT**

NAME	Amount Ordered	Amount Paid	State/County of Order

**D. HEALTH INSURANCE AVAILABLE THROUGH YOUR EMPLOYMENT:**

You must complete this paragraph if you *could get this kind of insurance through your job even if your children are not enrolled.*

Check with your Payroll or Human Resources Department to obtain amount of your monthly payroll contribution to the cost.

TOTAL MONTHLY FAMILY HEALTH INSURANCE COST TO EMPLOYEE \_\_\_\_\_

TOTAL MONTHLY TWO PERSON COST TO EMPLOYEE \_\_\_\_\_

TOTAL MONTHLY COST FOR SINGLE PERSON COVERAGE TO EMPLOYEE \_\_\_\_\_

**ARE CHILDREN OF THIS ACTION ENROLLED IN YOUR PLAN?**  Yes  No

**E. YOUR CHILD CARE COSTS FOR CHILDREN OF THIS RELATIONSHIP**

(If monthly amounts change during the year, use total annual amount divided by 12)

TOTAL MONTHLY CHILD CARE COSTS (before subsidy) \_\_\_\_\_

SUBSIDY \_\_\_\_\_

OUT OF POCKET COSTS (Total costs minus subsidy) \_\_\_\_\_

Transfer out of pocket costs to Page 9, line 51.

**F. YOUR EXTRAORDINARY EXPENSES FOR CHILDREN OF THIS RELATIONSHIP**

	Type of expense	Cost per month
Child's Uninsured Medical expenses		
Child's Educational Expenses		
Child's Special Needs Expenses		

**G. MONTHLY INCOME RECEIVED BY A CHILD OF THIS RELATIONSHIP**

INCOME SOURCE	Child's Name	Amount
1. DISABILITY BENEFITS		
2. SOCIAL SECURITY BENEFITS		
3. OTHER		
Name of Parent who receives the child's benefit: _____		

**SECTION IV - LOANS AND DEBTS**

**LOANS**

**A. Primary Residence Loans:**

Type of Loan	Lender	Balance owed	Monthly payment	Check here if YOU are making this payment
1. Primary Residence				
2. Second Mortgage				
3. Home Equity				
Total Primary Residence				

Transfer Monthly Payment Total to Page 7, Line 1

**B. Other Real Estate Loans - DO NOT include business or rental property loans**

Property Description	Lender	Balance Owed	Monthly Payment	Check here if YOU are making this payment
Total Other Real Estate				

Transfer Monthly Payment Total to Page 8, Line 38

**C. Vehicle Loans**

Type of Vehicle (Year, Make, Model)	Lender	Balance Owed	Monthly Payment	Check here if YOU are making this payment
Total Vehicle Loans				

Transfer Monthly Payment Total to Page 7, Line 14

**D. Other Loans**

Type of Loan	Lender	Balance Owed	Monthly payment	Check here if YOU are making this payment
Personal Loan				
School/College Loan				
Other				
Other				
Total				

Transfer Monthly Payment Total to Page 8, Line 38

**DEBTS**

**A. Credit Card Debt**

Card Holder	Company	Balance Owed	Monthly payment	Check here if YOU are making this payment
Total				

Transfer Monthly Payment Total to Page 8, Line 43

**B. Other Debts (for example tax liens, hospital bills, collection accounts)**

Type of Debt	Company/Entity Owed	Balance Due	Monthly payment if any	Check here if YOU are making this payment
Total				

Transfer Monthly Payment Total to Page 8, Line 38

## SECTION V - EXPENSES

### MONTHLY EXPENSES:

List your monthly expenses. For those expenses paid other than monthly, take the annual amount and divide it by 12. If amount paid changes from month to month, use the annual amount divided by 12.

<b>HOUSEHOLD EXPENSES-</b>	Amount paid by you	Amount paid by someone else	Total Household
1. Rent or Mortgages, including Home Equity Loans			
2. Property Taxes			
3. Home Owner's or Renter's Insurance			
4. Electricity			
5. Telephone (Land and Cell Phone)			
6. Water			
7. Gas for home			
8. Oil, Wood or other fuel not listed above			
9. Mowing, Plowing, Trash			
10. Groceries			
11. Cable/Internet			
12. Laundry/Dry Cleaning			
13. Maintenance/repair			
<b>TOTAL OF HOUSEHOLD EXPENSES</b>			

<b>VEHICLE EXPENSES</b>	Amount paid by you	Amount paid by someone else	Total Household
14. Total Vehicle Loans			
15. Car Insurance			
16. Gas			
17. Maintenance/Repairs			
18. Registration			
<b>TOTAL VEHICLE</b>			

<b>INSURANCE EXPENSES</b>	Amount paid by you	Amount paid by someone else	Total Household
19. Life Insurance			
20. Disability Insurance			
21. Health Insurance			
22. Dental/Vision			
<b>TOTAL INSURANCE</b>			

<b>YOUR PERSONAL EXPENSES</b>	Amount paid by you	Amount paid by someone else	Total
23. Uninsured Medical Expenses			
24. Clothing/Shoes			
25. Toiletries/Cosmetics			
26. Meals/Snacks eaten out			
27. Hair Care			
28. Magazines, Newspapers, Books, other reading material			
29. Tobacco and Alcohol Products			
30. Veterinarian and other pet expenses			
31. Entertainment (movies, bowling, museums, etc.)			
32. Gifts for others			
33. Charitable Contributions			
34. Vacation			
35. Union Dues			
36. Monthly Contribution to Savings			
37. Monthly Contribution to Retirement Funds (401K, IRA, etc.)			
38. Monthly Loan & Debt Payments ( <i>do not include primary residence loans, credit cards, or vehicle payments</i> )			
39. Expenses for Children living with you but not of this relationship			
40. Court Ordered Child Support you pay for children of another relationship.			
41. Court Ordered Spousal Maintenance (Alimony) you pay			
42. Miscellaneous (please list on a separate sheet and fill in total here)			
<b>TOTAL PERSONAL EXPENSES</b>			
<b>CREDIT CARD DEBT</b>	Amount paid by you	Amount paid by someone else	Total
43. <b>TOTAL Monthly Payments on Credit Cards</b>			
	Amount paid by you	Amount paid by someone else	Total
<b>GRAND TOTAL</b> of Household, Vehicle, Insurance and Personal Expenses and Credit Card Payments			



**INCOME TAX PAYMENTS**

<b>MONTHLY PAYROLL WITHHOLDING OR ESTIMATED TAXES</b>	
44. FEDERAL	
45. FICA	
46. MEDICARE	
47. STATE OF VERMONT	
48. OTHER TAXES WITHHELD/PAID	

**CHILDREN'S EXPENSES**

<b>MONTHLY EXPENSES FOR CHILDREN OF THIS RELATIONSHIP PAID BY YOU</b>	
49. Clothing and Shoes	
50. Diapers	
51. Out-of-Pocket Child Care Costs related to your employment	
52. School lunches	
53. School supplies	
54. Fees/expenses for special activities (e.g., piano lessons, sports)	
55. Summer Camp	
56. Private School Tuition	
57. Uninsured Medical/Dental Expenses	
58. Child Support you pay for your children of this relationship	
59. Miscellaneous: Please itemize below.	
Miscellaneous 1	
Miscellaneous 2	
Miscellaneous 3	
Miscellaneous 4	
<b>TOTAL MONTHLY EXPENSES FOR CHILDREN</b>	

RENTAL INCOME ATTACHMENT (Schedule E) A.

ANNUAL RENT RECEIVED

Line A

**B. ANNUAL RENTAL EXPENSES**

1. Cleaning and Maintenance	
2. Commissions	
3. Insurance	
4. Legal and Other Professional Fees	
5. Mortgage Interest Paid to Banks	
6. Other Interest	
7. Repairs	
8. Supplies	
9. Taxes	
10. Utilities	
11. Wages and Salaries	
12. Other (please list) a. _____	
b. _____	
c. _____	
d. _____	
13. Depreciation Expense	
TOTAL ANNUAL EXPENSES (Add Lines 1 through 13)	
TOTAL ANNUAL INCOME (Line A minus Line B)	
TOTAL MONTHLY INCOME (Line C divided by 12)	

**Line B**

**Line C**

Enter this amount on  
Page 2, B. Line 1,  
Section I) of Form 813A

**A. MONTHLY GROSS RECEIPTS OR SALES**

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**B. MONTHLY BUSINESS EXPENSES**

1. Cost of goods sold and/or operation		14. Office Expenses & Supplies	
2. Advertising		15. Laundry & Cleaning	
3. Bad debts from sales or service		16. Pension and/or profit sharing plan	
4. Auto Expense:      Gas                      _____ Insurance                      _____ Maintenance                      _____ Registration                      _____		17. Rent for leased business property	
		18. Machinery or Equipment	
		19. Other Business Property	
5. Commissions		20. Repairs	
6. Depletion		21. Supplies	
7. Depreciation		22. Taxes	
8. Dues & Publications		23. Travel	
9. Employee Benefit Program		24. Meals & Entertainment	
10. Insurance ( <i>other than Health</i> ) ( <i>Specify</i> )		25. Utilities & Telephone	
a.		26. Wages	
b.		27. Other ( <i>List &amp; Specify</i> )	
11. Interest paid on Mortgage ( <i>to banks</i> )		a.	
12. Other Interest Payment ( <i>Specify</i> )		b.	
		c.	
		d.	
		e.	
		f.	
		g.	
		<b>TOTAL MONTHLY BUSINESS EXPENSES</b> <b>(Add Lines 1 through 27)</b>	
		MONTHLY BUSINESS NET INCOME (Gross Receipts/Sales minus Expenses)	

Enter this amount on Page 2 A Line 3 (Section I) of Form 813A