STATE OF VERMONT

SUPERIOR COURT	FAMILY DIVISION
Unit	Docket No.

Plaintiff **Defendant**

Name	DOB	v.	Name	DOB

FINANCIAL AFFIDAVIT - NON-DIVORCE

INSTRUCTIONS: You are required to complete and file this financial affidavit as part of your court case. You must complete the form and file it with the Court at or before your first case management conference. You must also send or bring a copy of the form for the other party(s) as well, along with the other supporting financial documents listed on the conference notice. You may attach additional sheets as needed to provide complete information.

1. I am the ☐ Plaintiff ☐ Defendant ☐ Other____
2. My employer's name and address is: ____

   ____

   ☐ I am self-employed as a ____

   ☐ I am not currently employed because ____
3. My <u>**gross monthly income**</u> (before taxes and deductions) is as follows:
   If you are paid weekly, multiply weekly amount by 4.333.
   If you are paid every two weeks, multiply bi-weekly amount by 2.165.
   If your income varies through the year, divide your annual income by 12.

Type of Income	Amount
Salary and Wages ☐ This includes overtime	$
Expenses Paid by Employer	$
Self-Employment **If self-employed, must attach self-employment worksheet or IRS Schedule C*	$
Unemployment Benefits	$
Social Security Benefits Type_______________	$
Veteran's Benefits	$
Spousal Maintenance/Alimony ☐ This is from the other party in this case	$
Worker's Compensation or Disability Insurance	$
Other source(s) of income *(tips, rental income, gifts, interest, retirement benefits, etc. List below or attach separate sheet)*	$
TOTAL GROSS MONTHLY INCOME	$

4. I receive cash public assistance. ☐ Yes ☐ No If yes, list type and monthly amount: _____________________.

5. I have the following children not with the other party in this case:

Name	Date of Birth	Current Primary Residence Address

6. I am court-ordered to pay the following monthly amounts:

Type	Amount Ordered	Amount Paid	Issuing Court
Child Support for other children	$	$	
Spousal Maintenance/Alimony ☐ check if other party in this case	$	$	
Other *(specify):*	$	$	

7. I ☐ do ☐ do not have health insurance available through my employer *(if available, complete the following):*
   A. Total Monthly Cost: Family Plan _____________ 2 Person Plan_______________ Single Plan _____________
   B. The child(ren) in this case ☐ are ☐ are not enrolled in my health insurance plan.

8. I ☐ do ☐ do not have employment-related child care (day care/babysitting) costs for child(ren) in this case.
   If amounts change during the year, use the yearly amount divided by 12 months.
   Monthly Child Care Costs:_________ Monthly Child Care Subsidy _________Out of Pocket Costs:___________

9. Extraordinary Expenses for child(ren) in this case (*for ongoing extraordinary educational, medical or other special needs, specify type of expense and cost per month)*: ____
   ____

10. Monthly Income received by any child(ren) in this case (*specify child's name, type of income [social security, disability, or other], monthly amount, and person who receives the benefit on the child's behalf):*_______________________________
    ____

AFFIRMATION

I have read and filled in all of 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 and 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

____
Date Notary Public Commission Expires