

Financial Disclosure Affidavit (Short Form)
Notice to Parties in a Support Proceeding

In addition to this form, please provide copies of:

- Your two (2) most recent pay stubs
- Your most recent Federal and state tax returns,
- Your W-2s and/or 1099 statements
- All documents which prove the amount of other income and/or debt and loans
- Proof of health insurance coverage and cost
- Proof of public assistance

State of New York File #: _____
 County of _____ Docket #: _____
 Court Date, Time, and Part: _____

I, _____ (print name), being duly sworn, depose and say that the following is an accurate statement of my income, my assets, my expenses, and my liabilities:

Income Are you self-employed? Yes No

Employer: _____ Hours worked per week _____
Address: _____

Gross income (all jobs): \$ _____ per _____ Take-home income (all jobs): \$ _____ per _____

Other income (Public Assistance, SNAP, Rent, Tips, Unemployment Insurance benefits, Workers' Compensation, Social Security Disability (SSD), Supplemental Security Income (SSI), Pensions and Retirement Benefits, Fellowships/Stipends/Annuities, Investment Income, etc)

Amount	Source
\$ _____ per _____	_____
\$ _____ per _____	_____
\$ _____ per _____	_____

How many people are in your household? Me + _____ others
Income from other household members: \$ _____ per _____

Are you paying additional child support orders? Yes No. If yes, attach copies of all support orders.
How much? \$ _____ To whom? _____

Health Insurance Coverage You must bring in proof of your insurance coverage and the cost. If you have health insurance available through employment, but have not signed up for it, you still must bring proof of the coverage and cost.

My insurance coverage is None through my job privately purchased Medicaid Medicare

My coverage includes Medical Dental Vision Prescription

Insurance Plan Name: _____ Policy #: _____

The cost of my health insurance is
\$ _____ per _____ for a Family Plan. \$ _____ per _____ for an Individual Plan.

The child(ren)'s health insurance is covered by: my plan the other parent's plan Child Health Plus
 Medicaid Other: _____

D.R.L. §§ 236-B, 240

3/2018

Child Care (Provide receipts)

My child care provider is _____

The average number of hours per week that I need child care is _____. The cost is \$_____ per _____

Assets (Include additional page of other assets, if needed)

Savings Account: Bank name: _____ Balance: \$ _____

Checking Account: Bank name: _____ Balance: \$ _____

Automobile: Year: _____ Make: _____ Value: \$ _____
Model: _____

House/Apt Owned: Address: _____
Market value: \$ _____ Mortgage: \$ _____

Other assets: Details: _____ Value: \$ _____

(other real estate,
car, boat,
snowmobile, stocks,
bonds, trailer, etc.) Details: _____ Value: \$ _____

Expenses The following are my monthly expenses

Rent or mortgage: \$ _____ Health insurance: \$ _____

Utilities Gas: \$ _____ Other insurance Life: \$ _____

Phone/TV/internet: \$ _____ Auto: \$ _____

Electric: \$ _____ Home/Fire: \$ _____

Other: _____ \$ _____ Other: _____ \$ _____

Child care: \$ _____ Transportation \$ _____

School tuition and expenses: \$ _____ Auto payment: \$ _____

Food: \$ _____ Gasoline: \$ _____

Clothing: \$ _____ Public transportation: _____

Medical/Dental/Prescription: \$ _____ Other: _____ \$ _____

Contributions \$ _____ Total : \$ _____

Loans and Debt (Include additional page of other loans and debt, if needed)

Owed to: _____ For: _____

Balance: \$ _____ Payment: \$ _____ monthly weekly

Owed to: _____ For: _____

Balance: \$ _____ Payment: \$ _____ monthly weekly

I swear that the above information is true and correct as of (date) _____.

Signature

Sworn to before me on _____

Notary Public / (Deputy) Clerk of the Court