CFIN - Routing Information:
Please provide your case worker's ID and your ORS case number below so that the form can be sent to the proper team. If you do not know this information, contact the Office of Recovery Services at (801) 536-8500.

Case Worker ID: _____ **ORS Case Number:** _____

ORS/CSS Financial Statement

Return this completed form and **PROOF OF YOUR INCOME AND EXPENSES** to the Office of Recovery Services/Child Support Services (ORS/CSS). Use an additional page if needed. To qualify for an arrears payment based upon your financial circumstances, you must make a full disclosure of all sources of income and assets. Proof may be in the form of bills and payment receipts, canceled checks, verification letters, court orders, etc.

Your Name		SSN	DOB
Address	City	State	ZIP
Street Address (if different from above)			
Telephone	Other Telephone		

Present Household Information:

Name	DOB	Relationship
Total Present Household:		

Other Dependents:

Name	DOB	Relationship
Total Other Dependents:		

Section 1: Your Income Information

☐ I do not have any income due to being incarcerated. (If you check this box, please complete the information found in Section 2: Incarceration Information below.)

Please provide proof of income (current paycheck stubs, tax forms, etc.)

	Gross Amount	hr/wk/ 2wk/mo	Employer/Other Name	Address	Phone
Regular	$	per			
Other	$	per			
Previous Employer	$	per			

Monthly Support Payments Received by You:

Child Support $	Alimony $	Medical: $	Day Care $

☐ Check here if you do **not** receive any support payments

Monthly Government Payments Received by You:

Public Assistance $	Social Security $
Unemployment $	Other $

☐ Check here if you do **not** receive any government payments

Section 2: Incarceration Information

Name of Prison/Facility			
Address	City	State	ZIP

Will your time spent incarcerated be greater than 6 months? ☐ Yes ☐ No

Date of Incarceration:	Expected Date of Release, if known:

Section 3: Medical Insurance Information

	Company Name	Policy #	Monthly Premium costs: Individual	Family
Health			$	$
Dental			$	$
Optical			$	$
Name of Policyholder				
Names of Individuals Covered				

Section 4: Current Spouse's Income Information

Current Spouse/Partner's Income Information:

☐ I am not presently married

Spouse/Partner's Name	SSN	DOB

	Gross Amount	hr/wk/ 2wk/mo	Employer/Other Name	Address	Phone
Regular	$	per			
Other	$	per			
Previous Employer	$	per			

Monthly Support Payments Received by Current Spouse/Partner:

Child Support $	Alimony $	Medical: $	Day Care $

☐ My spouse/partner does **not** receive any support payments

Monthly Government Payments Received by Current Spouse/Partner:

Public Assistance $	Social Security $
Unemployment $	Other $

☐ My spouse/partner does **not** receive any government payments

Section 5: Assets and Investments Information

Assets:

	Institution	Branch	Account Number	Balance
Checking Account				$
Savings				$
Credit Union				$

Investments:

	Institution	Branch	Account Number	Balance
Certificates				$
Stocks/Bonds				$
				$
				$
Mutual Funds				$
			Total Investments	$

Other Information:

	Life Insurance (cash value)	$
Real Estate	Appraised value	$
	Mortgage amount	$
	Equity	$

Section 6: Monthly Support Obligations

Attach copies of court orders for all obligations claimed.

Child Support	$
Day Care Expenses	$
Alimony	$
Medical Support (court ordered)	$

Section 7: Monthly Expenses

Housing Expenses:

	Paid to	Address	Amount
Mortgage/Rent			$
Room and Board			$
Property tax			$
Insurance			$

Utilities:

Electricity $	Gas $	Water/Sewer $	Telephone (basic service only) $

Vehicles:

Make/Model	Year	Value	Loan Balance
		$	$
		$	$
		$	$

Monthly Vehicle Expenses:

	Payment	Repairs	Gas/Oil	Public Transportation
Yours	$	$	$	$
Spouse/Partner	$	$	$	$
Other	$	$	$	$

Vehicle Insurance:

	Company Name	Policy Number	Premium
Vehicle 1			$
Vehicle 2			$
Vehicle 3			$

Life Insurance:

	Company Name	Policy Number	Premium
Policy 1			$
Policy 2			$

Child Care:

Only include child care expenses for the child(ren) included in this order. Provide verification of amounts paid.			
	Child Name	Amount Paid	Frequency Paid (day/hour/etc.)
Child #1		$	
Child #2		$	
Child #3		$	
Child #4		$	

Other Debts:

Description/Company Name	Total Debt	Payment
		$
		$

ATTACH PROOF OF MONTHLY EXPENSES IN THE FORM OF BILLS AND PAYMENT RECEIPTS, CANCELED CHECKS, VERIFICATION LETTERS, ETC. AND RETURN TO THE ADDRESS LISTED BELOW.

Office of Recovery Services
PO Box 45033
Salt Lake City, UT 84145-0033

Signature:	**Date:**

NOTE: Based on section 466(a)(13) of the Social Security Act [42 U.S.C. 666(a)(13)] it is mandatory for a State's child support enforcement program to request an individual's social security account number in order to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations.