CSC No: _____
Party Name: _____
Dependents: _____
_____ _____ _____

FOSTER CARE FINANCIAL STATEMENT

FOSTER CARE RECOVERY UNIT
IOWA DEPT OF HUMAN SERVICES
DATE: _____

Docket No: _____
County: _____
Worker ID: _____
Phone: _____

COMPLETE THIS FORM USING BLACK INK AND RETURN IN 10 DAYS
Because this form becomes a public record, do not list any personal information such as:
►the name of employer(s), or ►addresses, or ►social security numbers, or ►telephone numbers

I am currently ☐Employed full-time ☐Employed part-time ☐Self-employed ☐Unemployed

Job Title or Occupation _____

I am paid: ☐weekly ☐bi-weekly (every other week) ☐twice a month ☐monthly

My paychecks are: ☐the same each pay period ☐different each pay period

The amount of my last paycheck (before deductions) was: $_____

(Attach your last three pay stubs. If self-employed, attach your last three income tax returns and all schedules).

I get income from other sources (not FIP or TANF benefits) ☐YES ☐NO

Attach proof of other income such as pay stubs, award letters, or tax returns

Check All That Apply:

☐Another Job $_____ ☐weekly ☐bi-weekly ☐twice a month ☐monthly
☐Unemployment $_____ ☐weekly ☐bi-weekly ☐twice a month ☐monthly
☐Worker's Compensation $_____ ☐weekly ☐bi-weekly ☐twice a month ☐monthly
☐Pension/Retirement $_____ ☐weekly ☐bi-weekly ☐twice a month ☐monthly
☐Veteran's Benefits $_____ monthly
☐Supplemental Security Income (SSI) $_____ monthly
☐Social Security Disability (SSD) or Social Security Retirement (SSR)
$_____ monthly and benefits are for: ☐myself ☐my spouse ☐my children
☐Alimony/Spousal Support I receive: $_____ ☐weekly ☐bi-weekly ☐twice a month ☐monthly
(Attach proof of payments received, and a copy of the order that contains the alimony/spousal support award)
☐**Other (for example commissions, tips. Please specify source)** _____
$_____ ☐weekly ☐bi-weekly ☐twice a month ☐monthly

List the cost for health or dental insurance that is available to you **even if you are not currently enrolled**. If you want to carry health insurance for the children through a stepparent you may provide that plan information.
IMPORTANT: Attach a copy (front and back) of your insurance card, completed enrollment form or verification that shows all of the plans available to you (or the stepparent), the costs and names of ALL people enrolled.

Family Health Insurance $_____ ☐weekly ☐bi-weekly ☐twice a month ☐monthly
Single Health Insurance $_____ ☐weekly ☐bi-weekly ☐twice a month ☐monthly

Select at least one:

☐ I currently carry OR ☐ my spouse currently carries a health plan that costs $_____per month
Included in the health plan ☐Self ☐Spouse ☐Children (# of children)_____

☐ Health insurance is available but I am not enrolled.

☐ Health insurance is not available.

☐ My children are on *hawk-i*. My cost is $_____per month.

I currently carry a ☐Family Dental Plan ☐Single Dental Plan
Family Dental Insurance $_____ ☐weekly ☐bi-weekly ☐twice a month ☐monthly
Single Dental Insurance $_____ ☐weekly ☐bi-weekly ☐twice a month ☐monthly

I am currently married ☐YES ☐NO

List the amounts you pay and **attach proof of the following deductions.**

Union Dues $_____ ☐weekly ☐bi-weekly ☐twice a month ☐monthly

You may only receive a mandatory pension deduction if **you do not contribute to Social Security**.

Mandatory Pension $_____ ☐weekly ☐bi-weekly ☐twice a month ☐monthly

Mandatory Occupational License Fees $_____ /per _____ (Enter a time period)

Who pays your fees? ☐I do ☐My employer does

If you pay the fees, do you deduct them on your tax return as a business expense? ☐YES ☐NO

You may receive credit for **other** court ordered child support, medical support, or alimony/spousal support you are paying.

	Monthly Amt:	Court order #:	County:	State:
I pay child support:	$_____	_____	_____	_____
I pay cash medical support:	$_____	_____	_____	_____
I pay alimony/spousal support:	$_____	_____	_____	_____

If you make payments through the clerk of court or another state, attach a copy of the court order and proof of payments. CSRU has records of payments made to the Iowa Collection Services Center.

I receive subsidized adoption benefits and the child's name is_____ ☐YES ☐NO

I have **other** children for whom I am legally responsible. ☐YES ☐NO **(Do not include stepchildren.)**

Child's Name	Date of Birth	Living Location	Relationship to Child
_____	_____	☐Foster Care ☐Home ☐Other	_____
☐ I or my spouse carry health insurance for the above child			
Child's Name	Date of Birth	Living Location	Relationship to Child
_____	_____	☐Foster Care ☐Home ☐Other	_____
☐ I or my spouse carry health insurance for the above child			
Child's Name	Date of Birth	Living Location	Relationship to Child
_____	_____	☐Foster Care ☐Home ☐Other	_____
☐ I or my spouse carry health insurance for the above child			

To get a deduction for qualifying children, you must provide proof of your parentage, such as: birth and marriage certificates, paternity affidavit, or court/administrative order. CSRU has records of paternity affidavits approved by the State of Iowa. To get a deduction for the cost of health insurance for these children, you must also provide proof of health insurance coverage, as requested on page one.

FOR PAYORS (person paying support) ONLY:

The children in this case stay overnight at least 128 times per year with me ☐YES ☐NO

This must be court ordered and a copy of the order must be attached. If the court ordered equally shared physical care, Extraordinary Visitation Credit does not apply.

SIGNATURE

I certify under penalty of perjury (punishment for lying) and under the laws of the State of Iowa that the above financial information I have given is true and correct. I understand that you may use this information in an action to establish or modify support for my children. I agree to accept service of all documents related to this action by first class mail. I further agree to inform your office of any change of address.

SIGN HERE: _____ DATE: _____

CSC No: _____
Party Name: _____
Dependents: _____ _____ _____
_____ _____

FOSTER CARE FINANCIAL STATEMENT

FOSTER CARE RECOVERY UNIT
IOWA DEPT OF HUMAN SERVICES

DATE: _____

Docket No: _____
County: _____

Worker ID: _____
Phone: _____

OTHER HOUSEHOLD INCOME

My spouse/partner is currently ☐Employed full-time ☐Employed part-time ☐Self-employed ☐Unemployed
Job Title/Occupation: _____
Spouse/Partner is paid: ☐weekly ☐bi-weekly ☐twice a month ☐monthly
The amount of each paycheck (before deductions) is: $_____

MY MONTHLY EXPENSES

Monthly House Payment or Rent: $_____
Monthly Utilities (Such as heat, gas, water, and electric): $_____
Monthly Cost of Meals or Food: $_____
Monthly Telephone/Cell Phone Costs: $_____
Monthly Clothing Costs: $_____
Monthly Cable T.V. Costs: $_____
Monthly Car Expenses (Not the amount of your car loan payment): $_____
Monthly Internet Service: $_____
Other expenses paid monthly: $_____
Please specify other expenses: _____
There are other people who help pay my monthly expenses ☐YES ☐NO
(Do not include the spouse/partner listed above).
If yes, list the amount they pay each month $_____

MY MONTHLY DEBTS/INSTALLMENT PAYMENTS

For example: department stores, loan companies, banks, or auto loans. (If you need more space, please attach a separate sheet of paper.)

Payable to/Item	Monthly Payment Amount	Balance Due
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____

MY ASSETS

Balance in Savings Account: $_____ Name of Bank: _____
Balance in Checking Account: $_____ Name of Bank: _____
Real Estate Value: $_____ Balance owed on real estate: $_____
Stocks: $_____ Bonds: $_____
Vehicles:
Type: _____ Year: _____ Make: _____ Model: _____
Type: _____ Year: _____ Make: _____ Model: _____

SIGNATURE

I certify under penalty of perjury (punishment for lying) and under the laws of the State of Iowa that the above financial information I have given is true and correct. I understand that you may use this information in an action to establish or modify support for my children. I agree to accept service of all documents related to this action by first class mail. I further agree to inform your office of any change of address.

SIGN HERE: _____ DATE: _____

Iowa Department of Human Services

Request for Additional Financial Information

_____
_____
_____
_____

Date: _____
Case Number: _____
Worker ID: _____

Foster Care Recovery Unit
_____
_____
_____
Phone: _____

We need more financial information from you to set your child support. The amount of your child support is based on the Iowa Supreme Court guidelines.

After you fill out the form, send it to the office listed at the top of the page. Please return the form within 10 days of the date of this request.

We may provide a copy of this form to the other parent. We may file this information with the court. If so, the information will become public record.

If you have questions about filling out this form, please contact your local office (see address and phone number above).