CONFIDENTIAL DIVORCE/LEGAL SEPARATION CLIENT QUESTIONNAIRE (NO MINOR CHILDREN)

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DATE OF MARRIAGE: _____

PLACE OF MARRIAGE: _____

DATE OF SEPARATION: _____

HUSBAND'S/PARTNER'S NAME (FIRST, MIDDLE)	(LAST)
FORMER LEGAL NAMES (If any)	
RESIDENCE OR LEGAL ADDRESS: STREET AND NUMBER	CITY COUNTY STATE /ZIP
SOCIAL SECURITY NUMBER BIRTHPLACE	DATE OF BIRTH AGE
HOME TELEPHONE EMPLOYER	ADDRESS WORK TELEPHONE
DRIVERS LICENSE NO.	STATE WHERE ISSUED
RACE EDUCATION (LAST GRADE COMPLETED)	NUMBER OF THIS MARRIAGE (First, Second, etc.)
IF PREVIOUSLY MARRIED, LAST MARRIAGE ENDED:	
By Death, Divorce, Dissolution or Annulment (please specify)	DATE (Month, Day, Year)

WIFE'S/PARTNER'S NAME (FIRST, MIDDLE)	(LAST)
FORMER LEGAL NAMES (If any)	
RESIDENCE OR LEGAL ADDRESS STREET AND NUMBER	CITY COUNTY STATE /ZIP
SOCIAL SECURITY NUMBER BIRTHPLACE	DATE OF BIRTH AGE
HOME TELEPHONE EMPLOYER	ADDRESS WORK TELEPHONE
DRIVERS LICENSE NO.	STATE WHERE ISSUED
RACE EDUCATION (LAST GRADE COMPLETED)	NUMBER OF THIS MARRIAGE (First, Second, etc.)
IF PREVIOUSLY MARRIED, LAST MARRIAGE ENDED:	
By Death, Divorce, Dissolution or Annulment (please specify)	DATE (Month, Day, Year)

Type of Asset	Jointly Owned*	Owned by Husband	Owned by Wife
Bank Accounts – Checking/Savings/CDs: 1. 2. 3.			
Stocks and Bonds or Mutual Funds: 1. 2. 3.			
Closely-Held Businesses: 1.			
Real Estate – Your Home(s): 1. 2.			
Real Estate – Other: 1. 2. 3.			
Vehicles: (list VIN numbers): 1. 2. 3. 4.			
Life Insurance ***: 1. 2.			
Pension, Profit Sharing or IRA Benefits: 1. 2.			
Expectancies (Inheritances or Gifts): 1.			
Other Assets (Please itemize): 1. 2.			
TOTALS:			

Income, Deductions and Medical/Dental Insurance

You must complete and submit the following attachments. Copies of recent (1) federal and state income tax returns, (2) last four pay stubs, and (3) if self-employed, most recent profit and loss statement.

Your Monthly Gross Income:		
A.	**From Employment.** If paid weekly, multiply weekly income by 4.3 to arrive at a monthly gross income and insert below. If paid every two weeks, multiply two weeks' income by 2.15 and insert below. Gross Hourly Wage: $_____ Average Number of Hours Worked Per Week: _____ Gross Monthly Income: Gross Monthly Tips/Commissions/Bonuses (identify):_____ _____	Monthly Amount $_____ $_____
	SUBTOTAL: A.	$_____
B.	**From Self-Employment.** If you own an interest in a partnership or in a closely held corporation, attach last year's Schedule K-1, and/or corporation federal income tax return. Gross Receipts: Expense Reimbursements: Rental Income: Royalty Income: **Less** Ordinary/Necessary Expenses: **Plus** Monthly Portion of Accelerated Component of any Depreciation Allowance or Investment Tax Credits:	 $_____ $_____ $_____ $_____ $_____ $_____
	SUBTOTAL: B.	$_____
C.	**Other Sources of Income.** (Please attach verification of any income available to you as listed below.) Description: Dividends: Interest Income: Trust Income: Contract Payments (less underlying debt): Annuity Income: Retirement/Pension/IRA/Keogh Benefits (not Social Security): Social Security Income: Workers' Compensation Benefits per week multiplied by 4.3 = Monthly Amount Unemployment Benefits per week multiplied by 4.3 = Monthly Amount Disability Income: Gifts or Prizes: Spousal Support: Expense Reimbursements and/or Per Diem Allowance (not listed in item B. above): ADC Benefits: FCAS (food stamps): Other (specify): _____ _____	 $_____ $_____ $_____ $_____ $_____ $_____ $_____ $_____ $_____ $_____ $_____ $_____ $_____ $_____ $_____ $_____ $_____
	SUBTOTAL: C.	$_____
D.	**Summary of Your Gross Monthly Income.** Income From Employment (item A. above) Self-Employment Income (item B. above) Other Income (item C. above)	Monthly Amt. $_____ $_____ $_____

YOUR TOTAL MONTHLY GROSS INCOME: D.	$_____

Your Monthly Deductions From Gross Income:

A. **Mandatory Deductions.**	Monthly Amount
Number of exemptions claimed by you: _____	
Description:	
State Income Taxes:	$_____
Federal Income Taxes:	$_____
Social Security (FICA):	$_____
Workers' Compensation Insurance Premium:	$_____
Wage Withholding, Wage Assignment or Garnishment (Paid to: _____)	$_____
Medical Insurance for the Parties' Joint Children	$_____
If Additional Premiums: Total Premium ($_____) **less** cost of coverage for yourself **plus** other dependents = Monthly Amount	$_____
SUBTOTAL OF MANDATORY DEDUCTIONS: A.	$_____

B. **Optional Deductions.**	
Description:	
Retirement/Profit Sharing:	$_____
Savings Plan:	$_____
Credit Union:	$_____
Other:_____	$_____
SUBTOTAL OF OPTIONAL DEDUCTIONS: B.	$_____

C. **Summary of Deductions.**	
Mandatory - from item A. above	$_____
Optional - from item B. above	$_____
TOTAL MONTHLY DEDUCTIONS: C.	$_____

Information for Medical and Dental Insurance Coverage: (For children listed on Page __, item __, which is currently provided or available for the benefit of those children.)

☑ I provide this. (Complete information below)
❒ Other parent provides this. (Complete information below, if known)

Item	Health Insurance	Dental Insurance
Name of Insurance Company:		
Plan or Group Name:		
Plan or Group Number:		
Individual I.D. Number:		
Address for Claims Submission:		
Telephone Number for Information:		
Amount of Annual Deductible:		
Gross Monthly Premium Actually Paid by You (exclude amounts paid by your employer):		
Monthly Premium to Cover Only You:		
Dependent's Portion of Monthly Premium:		

Are there dependents other than the children on Page 1, item 6, of this Affidavit enrolled with the plan?

Yes ❒ No ☐ If "YES," total number of other dependents: _____

Monthly Expenses

You *must* complete this schedule and prepare and submit the attachments requested in this schedule if either party seeks spousal support or any change from the Uniform Child Support Guidelines. These are the total household expenses you must pay each month. Utility bills should be averaged over the year. Any other annual, quarterly, or other periodic payments should be converted to a monthly average. DO NOT LIST ANY EXPENSE IF IT IS DEDUCTED FROM YOUR WAGES. *ONLY INCLUDE DIRECT EXPENSES FOR JOINT CHILDREN IN SECTION 1*.

1.	**Direct *monthly* expenses *for children of this relationship* which you pay:**	
A.	School Expenses. 1. School Lunches: 2. Books, Tuition: 3. Activities: 4. Other (specify):_____	Monthly Amount $_____ $_____ $_____ $_____
B.	Food (other than school lunches):	$_____
C.	Day-care:	$_____
D.	Clothing:	$_____
E.	Medical Insurance--Premium Payments:	$_____
F.	Unreimbursed Health Costs:	$_____
G.	Unreimbursed Dental Costs:	$_____
H.	Child-care (not work-related):	$_____
I.	Lessons:	$_____
J.	Grooming Needs:	$_____
K.	Hobbies, Recreation:	$_____
L.	Entertainment:	$_____
M.	Allowances:	$_____
N.	Transportation: 1. Gasoline, Oil: 2. Insurance for Driving-Age Child:	 $_____ $_____
O.	Miscellaneous (specify):_____	$_____
TOTAL DIRECT EXPENSES OF CHILDREN: (Add 1.A. through 1.O.)	1.	$_____

Average Monthly Amount of Child's Income:	SOURCE	AMOUNT	NAME

1.	**Fixed Costs:**	
A.	Residence:	Monthly Amount
	Mortgage or Rent:	$_____
	Second Mortgage:	$_____
	Property Taxes (if not included in mortgage payment):	$_____
	Other (specify):_____	$_____
B.	Utilities:	
	Electricity:	$_____
	Heat (other than electricity):	$_____
	Water:	$_____
	Telephone:	$_____
	Garbage:	$_____
	Other (specify): Sewer	$_____
C.	Transportation:	
	Car Payments:	$_____
	Maintenance and Repairs:	$_____
	Gas and Oil:	$_____
	Other (specify):_____	$_____
D.	Insurance:	
	Life:	$_____
	Medical/Dental:	$_____
	Automobile:	$_____
	Residence (included in mortgage payment):	$_____
E.	Food and Household Items: (exclude food expenses for joint children covered in Schedule 1, part 1, above)	$_____
F.	Clothing:_____ Grooming/Personal Needs:_____	$_____
G.	Medicine and Pharmaceutical--unreimbursed medical/dental costs:	$_____
H.	Court/DHR-Ordered Support Payments:	$_____
	TOTAL FIXED COSTS (A-H): 1.	$_____

2. Consumer Obligations:

Name of Creditor	Balance Due	Monthly Payments
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
TOTAL MONTHLY PAYMENTS ON CONSUMER OBLIGATIONS: 2.		$_____

3.	**Discretionary Expenses:**	
A.	Entertainment:	$_____
B.	Vacations:	$_____
C.	Gifts:	$_____
D.	Religious Contributions:	$_____
E.	Dues and Subscriptions:	$_____
F.	Club Memberships and Dues:	$_____
	TOTAL DISCRETIONARY EXPENSES: 3.	$_____
4.	**Additional Expenses:**	
A.	T.V. Cable:	$_____
B.	Bus Fare:	$_____
C.	Parking Costs:	$_____
D.	Disability Insurance:	$_____
E.	Home Repairs:	$_____
F.	Laundry and Dry Cleaning:	$_____
G.	Pet Expenses:	$_____
H.	Attorney Fees:	$_____
I.	Other (Specify):	$_____
	TOTAL ADDITIONAL EXPENSES: 4.	$_____
5.	**TOTAL EXPENSES EXCLUDING DIRECT EXPENSES OF CHILD:** (Add 1, 2, 3 and 4) **5.**	$_____
6.	**Other Factors:** Other factors that affect my income and expenses or that should be considered to rebut the presumptive child support calculations. Attach supporting documentation whenever possible: **6.**	$_____