

**COURT OF COMMON PLEAS
DIVISION OF DOMESTIC RELATIONS
CUYAHOGA COUNTY, OHIO**

Plaintiff

Date of Birth

Address

City, State, Zip Code
Marital Residence: Yes No

Case Number: _____

Judge: _____

vs

**COUNTER AFFIDAVIT TO
MOTION FOR TEMPORARY SUPPORT**

Defendant

Date of Birth

Address

City, State, Zip Code
Marital Residence: Yes No

Filed by: _____
(Your Name)
WIFE HUSBAND

Date of Marriage: _____

Date of Separation: _____

Plaintiff Defendant in the above-entitled action hereby files his/her Counter Affidavit to the Motion for Temporary Support filed by Plaintiff Defendant.

Plaintiff Defendant herein _____, having been duly sworn states that he/she has been advised that this affidavit will be used for the following purposes: (1) to disclose completely affiant's income and expenses; (2) to assist in determining orders of child support and spousal support, and payment of debts and expenses when applicable or any changes thereto; and (3) to provide for the issuance of an appropriate support withholding and deduction notice or other order.

Initial: _____

I. Information Required for Support Calculation:

A. Minor or Dependent Children of this Marriage
(Include adopted children and any child of the parties who is over 18 and still attending high school or is mentally or physically disabled)

Child's Name	Date of Birth	Age	Residing with

ARE THERE ANY OTHER SUPPORT ORDERS ESTABLISHED FOR THESE CHILDREN? YES NO
IF YES, ATTACH COPY OF ORDER AND PROVIDE THE FOLLOWING INFORMATION: DATE OF ORDER: _____ AMOUNT: \$ _____

CASE NUMBER: _____ SETS NUMBER: _____ COURT (or agency) NAME: _____

B. Other Minor Children Living in My Household.

Child's Name	Child's Relationship to You	Date of Birth	Age	Court Ordered Support Received
				\$
				\$
				\$

C. Other Minor Children of Mine, NOT Living in My Household.

Child's Name	Residing with	Date of Birth	Age	Court Ordered Support Paid
				\$
				\$
				\$

II. Child Support Guideline Adjustment:

	Husband/Father (all figures per year)	Wife/Mother (all figures per year)
Total court ordered child support you pay for other children	\$	\$
Total court ordered spousal support you pay to former spouse(s)	\$	\$
Number of your other dependent children living with you from another marriage or relationship		
Court ordered child support you receive for the dependent child(ren) you indicated on line above	\$	\$
Childcare expenses you pay for child(ren) of this marriage (employment or educational related)	\$	\$
Local income taxes paid or rate of tax where you live or work	\$ %	\$ %
Self-employment tax (5.6% of A.G.I.)	\$	\$
Health insurance premium for children (family plan cost minus individual plan cost)	\$	\$

III. Annual Income [as defined in Ohio Revised Code §3119.01(B)(5)]:

A. Gross Annual Income from Employment (If not known, please estimate and write "EST" after each estimated figure.)

Gross Annual Employment Income ▶	Husband/Father		Wife/Mother	
	\$	<input type="checkbox"/> Salary <input type="checkbox"/> Wages	\$	<input type="checkbox"/> Salary <input type="checkbox"/> Wages
Name(s) of Employer(s)				
Payroll Address(es)				
City, State, Zip				
Check the number of paychecks per year	<input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> 26 <input type="checkbox"/> 52		<input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> 26 <input type="checkbox"/> 52	
Year-to-date Gross Income	\$	Through date of:	\$	Through date of:
Prior Year's Tax Refund	\$		\$	
Benefits from Employment (Company Car, Club Memberships, Stock Options, etc.)				
1.	\$		\$	
2.	\$		\$	
3.	\$		\$	
Total Annual Value of Benefits:	\$		\$	

Initial: _____

B. Annual Overtime, Commissions and Bonuses (If not known, please estimate and write "EST" after each estimated figure.)

				Husband/Father		Wife/Mother	
				Base Income	Overtime, Commissions & Bonuses	Base Income	Overtime, Commissions & Bonuses
LAST YEAR:				\$	\$	\$	\$
2 YEARS AGO:				\$	\$	\$	\$
3 YEARS AGO:				\$	\$	\$	\$
THIS YEAR THROUGH	Month	Day	Year	\$	\$	\$	\$

C. Gross Annual Self-Employment Income (If not known, please estimate and write "EST" after each estimated figure.)
Use gross annual figures for most recent full year. See Ohio Revised Code §3119.01(C)(13)

Gross Annual Business Receipts	\$	Company Name	
Ordinary & Necessary Business Expenses	- \$	Company Address	
Net Annual Business Income	= \$	Nature of Business:	

D. Other Annual Income: Other income includes commissions (other than from employment), royalties, tips, rents, dividends, severance pay, interest, trust income, annuities, social security benefits (including retirement, disability and survivor benefits that are not need based), workers' compensation, unemployment insurance, spousal support actually received, recurring capital gains, etc. Also include military pay (including base pay, BAQ, BAS, specialty pay, variable housing allowance, training pay, combat pay, hazardous duty pay, etc). Need Based Assistance includes benefits received from a government-administered means-tested program such as Ohio works first, food stamps, SSI, disability financial assistance, etc. For complete definition of income see Ohio Revised Code Section 3119.01(C)(7). If exact amounts are not known, please estimate and write "EST" after each estimated figure.

If more space is needed, attach extra pages.

See additional pages: YES

Husband/Father				Wife/Mother			
Other Income (Describe)		Need Based Assistance		Other Income (Describe)		Need Based Assistance	
	\$		\$		\$		\$
	\$		\$		\$		\$
	\$		\$		\$		\$
	\$		\$		\$		\$
Total Other Income	\$	Total Need Based Assistance	\$	Total Other Income	\$	Total Need Based Assistance	\$

E. Available Monthly Income

Husband/Father				Wife/Mother			
Average Monthly Deductions		Total Gross Annual Income		Average Monthly Deductions		Total Gross Annual Income	
Fed/State/Local Taxes	\$	Total Average Gross Monthly Income	Divide Gross Annual By 12 \$	Fed/State/Local Taxes	\$	Total Average Gross Monthly Income	Divide Gross Annual By 12 \$
Social Security Medicare	\$			Social Security Medicare	\$		
Health Insurance	\$	Average Monthly Deductions	Minus \$	Health Insurance	\$	Average Monthly Deductions	Minus \$
Union Dues	\$			Union Dues	\$		
Pensions	\$	Available Monthly Income	Equals \$	Pensions	\$	Available Monthly Income	Equals \$
IRAs/401(k)s	\$			IRAs/401(k)s	\$		
Support Orders	\$	Other:		Support Orders	\$	Other:	
Other:	\$			Other:	\$		
Total Average Deductions	\$			Total Average Deductions	\$		

IV. **Affiant's Monthly Living Expenses:** On pages 4 and 5 please list the **ACTUAL** expenses for your present household. Give estimated expenses if you do not have exact figures, and check the appropriate box if you give an estimated expense.

Initial: _____

A. MONTHLY HOUSING EXPENSES	Check box to right of each ESTIMATED expense
RENT OR FIRST MORTGAGE (circle one)	\$ <input type="checkbox"/>
REAL ESTATE TAXES (if not included above)	\$ <input type="checkbox"/>
REAL ESTATE/HOMEOWNERS INSURANCE (if not included above)	\$ <input type="checkbox"/>
SECOND MORTGAGE or EQUITY LINE, if any	\$ <input type="checkbox"/>
UTILITIES:	
• Electric (level billing or average/month)	\$ <input type="checkbox"/>
• Gas (if billed separately)	\$ <input type="checkbox"/>
• Fuel Oil/Propane	\$ <input type="checkbox"/>
• Water and Sewer	\$ <input type="checkbox"/>
• Telephone (basic monthly charge & average long distance)	\$ <input type="checkbox"/>
• Cable Television	\$ <input type="checkbox"/>
CLEANING, MAINTENANCE, REPAIR	
• Cleaning Service	\$ <input type="checkbox"/>
• Maintenance and home repairs Expenses	\$ <input type="checkbox"/>
LAWN SERVICE AND SNOW REMOVAL	\$ <input type="checkbox"/>
OTHER (specify):	\$ <input type="checkbox"/>
TOTAL HOUSING (A)	\$
B. OTHER MONTHLY LIVING EXPENSES	Check box to right of each ESTIMATED expense
FOOD, ETC.:	
• Groceries (include food, paper and cleaning products, toiletries, etc.)	\$ <input type="checkbox"/>
• Restaurant	\$ <input type="checkbox"/>
TRANSPORTATION, ETC.	
• Vehicle Loans and/or Leases	\$ <input type="checkbox"/>
• Vehicle Maintenance	\$ <input type="checkbox"/>
• Gasoline	\$ <input type="checkbox"/>
• Parking, Public Transportation	\$ <input type="checkbox"/>
CLOTHING, ETC.	
• Clothes (other than for children)	\$ <input type="checkbox"/>
• Dry Cleaning, Laundry	\$ <input type="checkbox"/>
PERSONAL GROOMING	\$ <input type="checkbox"/>
	\$ <input type="checkbox"/>
	\$ <input type="checkbox"/>
CELL PHONE	\$ <input type="checkbox"/>
OTHER (Specify):	\$ <input type="checkbox"/>
	\$ <input type="checkbox"/>
TOTAL OTHER LIVING EXPENSES (B)	\$

C. MONTHLY CHILD RELATED EXPENSES	Check box to right of each ESTIMATED expense	
Work/Educational Related Childcare	\$ <input type="checkbox"/>	
Clothing	\$ <input type="checkbox"/>	
School Supplies	\$ <input type="checkbox"/>	
Children's Allowances	\$ <input type="checkbox"/>	
Extracurricular Activities, Lessons	\$ <input type="checkbox"/>	
School Lunches	\$ <input type="checkbox"/>	
Other:	\$ <input type="checkbox"/>	
TOTAL CHILD RELATED EXPENSES (C)	\$ <input type="checkbox"/>	
D. MONTHLY INSURANCE PREMIUMS	Check box to right of each ESTIMATED expense	
Life	\$ <input type="checkbox"/>	
Auto	\$ <input type="checkbox"/>	
Health	\$ <input type="checkbox"/>	
Disability	\$ <input type="checkbox"/>	
Renters/Personal Property	\$ <input type="checkbox"/>	
Other (specify):	\$ <input type="checkbox"/>	
TOTAL INSURANCE PREMIUMS (D)	\$	
E. MONTHLY EDUCATIONAL EXPENSES	Check box to right of each ESTIMATED expense	
Description	You	Children
Tuition	\$ <input type="checkbox"/>	\$ <input type="checkbox"/>
Books, Fees, etc.	\$ <input type="checkbox"/>	\$ <input type="checkbox"/>
College Loan Repayment	\$ <input type="checkbox"/>	\$ <input type="checkbox"/>
Other:	\$ <input type="checkbox"/>	\$ <input type="checkbox"/>
Total Education Expenses for Each Column	\$	\$
TOTAL EDUCATION (E) (Add Both Columns)	\$	
F. MONTHLY HEALTH CARE EXPENSES (Not covered by insurance)	Check box to right of each ESTIMATED expense	
Description	You	Children
Physicians	\$ <input type="checkbox"/>	\$ <input type="checkbox"/>
Dentists	\$ <input type="checkbox"/>	\$ <input type="checkbox"/>
Optometrists/Opticians	\$ <input type="checkbox"/>	\$ <input type="checkbox"/>
Prescriptions	\$ <input type="checkbox"/>	\$ <input type="checkbox"/>
Other (specify):	\$ <input type="checkbox"/>	\$ <input type="checkbox"/>
Total Health Care Expenses for Each Column.	\$	\$
TOTAL HEALTH CARE EXPENSES (F) (Add Both Columns)	\$	

Initial: _____

OATH / AFFIRMATION

I, (print name) _____, hereby swear or affirm that the information set forth in this Affidavit is true, complete, and accurate, and that I have not willfully withheld any substantial asset, debt, income or expense. I understand that failure to fully complete this affidavit may result in monetary sanctions against me as set forth in R.C. 3105.171(E)(5). Falsification of this document may also subject me to criminal penalties for perjury (R.C. 2921.11) or a finding of contempt.

Affiant

Sworn to and subscribed before me this _____ day of _____, 20_____.

Notary Public



NOTICE: The Court may issue a temporary support order without a hearing upon submission of this counter affidavit and the affidavit of the other party. Please review Local Rule 23 for additional information about the Court's procedure for handling Motions for Temporary Support.

CERTIFICATE OF SERVICE

The Motion for Temporary Support with Affidavit and Notice was sent by certified ordinary mail to:

(Name of Attorney or Party)

(Address)

(City/State/Zip)

on _____
(Date sent)

PRINT NAME

SIGNATURE

ADDRESS

CITY, STATE, ZIP CODE

MOBILE TELEPHONE NUMBER

EMAIL ADDRESS

Signature of Attorney for Plaintiff Defendant

Attorney's Name and Registration Number

Address

City/State/Zip

Telephone Number

Initial: _____