



CUYAHOGA COUNTY COURT OF COMMON PLEAS
DIVISION OF DOMESTIC RELATIONS

THE STATE OF OHIO
Cuyahoga County

IN THE COURT OF COMMON PLEAS
INSTRUCTIONS FOR SERVICE

v.

Case No. DR _____

Judge _____

Method of Service

CERTIFIED MAIL

ORDINARY MAIL

REGISTERED MAIL

PERSONAL (Please specify type)

RESIDENCE (Please specify type)

CUYAHOGA COUNTY SHERIFF

CUYAHOGA COUNTY SHERIFF

OUT OF COUNTY SHERIFF _____

OUT OF COUNTY SHERIFF _____

PROCESS SERVER _____

PROCESS SERVER _____

Name and Address of Party to Serve:

Name: _____

Street Address: _____

City/State/Zip: _____

Filing Party/ Attorney of Record

INSTRUCTIONS FOR COMPLETING AND FILING MOTION TO MODIFY CHILD SUPPORT

The Motion to Modify Child Support must be supported by an Affidavit stating the reasons you think a new support order should issue. You are also required to prepare and submit a Post Decree Income and Expense Affidavit and a Health Insurance Affidavit, both found on this Website. A completed Child Support Computation Worksheet, found on this website, must also be presented when you come to the hearing on your motion.

Caption: On the line labeled "Plaintiff/Petitioner-01" fill in the name of the same person who was the original Plaintiff or Petitioner-01 when the case was first filed.

On the line labeled "Defendant/Petitioner-02/Respondent fill in the name of the person who was the original Defendant, Petitioner-02 or Respondent when the case was first filed.

Fill in the same case number and judge assigned by the Clerk of Courts when the case was first filed.

Paragraph 1: Fill in your name and whether you are "Plaintiff", "Defendant", etc. on the line in the first paragraph. Check the appropriate box indicating whether you are seeking an increase or a decrease in support.

Paragraph 2: Fill in the date the last support order was issued. (This date is on the stamp marked "Received for Filing" on the last page of the last order.)

Paragraph 3: Prepare and attach a Notarized Affidavit (last page) specifically stating the reason(s) why you want to have the support order changed.

Signature: Print your name on the first line, sign it on the second line, and print your address and daytime telephone number.

FILING THE MOTION TO MODIFY CHILD SUPPORT

You must file the motion with the Clerk of Court located in Room 35, on the ground floor of the Cuyahoga County Courthouse, 1 W. Lakeside Ave., Cleveland, Ohio 44113. You will be required to pay a "filing fee" to the Clerk of Court at the time you file the motion. Please refer to Local Rule 1 of this Court's Rules for the correct amount.

SERVICE

The Court cannot consider your motion unless it has been "served" on your spouse. The motion you file must be "served" by the Clerk of Court (not by you). A commonly used method of service is by certified mail. You must instruct the Clerk to do this by filing "Instructions for Service".

If the mail is returned to the Clerk from the Postal Service as unclaimed or refused, that information is posted on the "docket" in your case, and you will be notified by postcard. You must then instruct the Clerk to send service by ordinary mail. To do this, you must file a new "Instructions for Service" form, with a copy of the motion attached, requesting that service be made by regular mail.

PLEASE NOTE: IT IS YOUR RESPONSIBILITY TO MAKE SURE SERVICE IS COMPLETED. THIS WEBSITE DOES NOT EXPLAIN OTHER LEGAL METHODS OF SERVICE. FOR FURTHER INFORMATION REFER TO RULES 4 THROUGH 4.6 OF THE OHIO RULES OF CIVIL PROCEDURE.

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

_____ : CASE NO. DR: _____
PLAINTIFF/PETITIONER-01

_____ :
ADDRESS

_____ :
CITY/STATE/ZIP

vs.

JUDGE _____

_____ :
DEFENDANT/PETITIONER-02
RESPONDENT

**MOTION TO MODIFY CHILD
SUPPORT**

_____ :
ADDRESS

_____ :
CITY/STATE/ZIP

Now comes _____, and moves this Honorable Court for
an order decreasing increasing his/her current support for the minor child(ren).

The previous child support order was issued on _____.

The reason(s) for this request are stated in the attached affidavit.

Respectfully submitted,

PRINT NAME

SIGNATURE

ADDRESS

CITY, STATE, ZIP CODE

MOBILE TELEPHONE NUMBER

EMAIL ADDRESS

Case Number: _____

STATEMENT IN SUPPORT

This statement is made by: _____ *(insert name)*

- 1. _____

- 2. _____

- 3. _____

- 4. _____

- 5. _____

STATEMENT OF TRUTH

The information above is true, complete, and accurate to the best of my knowledge. I understand that knowingly providing false information in this document may result in a contempt of court finding against me which could result in a jail sentence and fine, or criminal penalties under R.C. 2921.13.

Signature

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

Plaintiff/Petitioner/Defendant-01

Address

Defendant/Respondent/Defendant-02

Address

Case Number _____

Judge _____

**PARENTING PROCEEDING STATEMENT
(ORC 3127.23)**

_____, states the following regarding issues relevant to
(Your name)
parenting of the following minor child(ren): (Names and birth dates of children) _____

DIRECTIONS: You must answer questions and provide all information requested. If you do not, it is possible the Court will be unable to make orders in your case. If you need more space to answer any question, please use a separate piece of paper and attach it to the back of this form. If the answers/information are not the same for all children, a separate affidavit must be filed for each child.

1. Beginning with the child(ren)'s present address, state the residence where the child(ren) lived within the last five years, and the names and relationship of the persons with whom the child(ren) lived during that period.

<u>Period of Residence</u>	<u>Address and Person(s) at residence</u>	<u>Person(s) Relationship to Child</u>
a. _____ to the present	a. _____	a. _____
b. _____ to _____	b. _____	b. _____
c. _____ to _____	c. _____	c. _____

2. Have you participated as a party, witness, or in any other capacity in any other proceedings concerning the allocation, between the parents of the same child, of parental rights and responsibilities for the care of the child including parenting time rights and the designation of the residential parent and legal custodian of the child or that otherwise concerned the custody of or visitation with the same child? No Yes

If "Yes" you must provide the Court name, address, case number and date of determination, if any on the line below:

3. Do you know of any proceedings that could affect the current proceeding, including proceedings for enforcement of child custody determinations; proceedings relating to domestic violence or protection orders; proceedings to adjudicate the child as an abused, neglected, or dependent child; proceedings seeking termination of parental rights; and adoptions? No Yes

If "Yes" you must provide the Court name, address, case number and date of determination, if any on the line below:

4. State the **name and address** of any person or agency who is not a party to this proceeding and has physical custody of the child or claims to be a parent of the child who is designated the residential parent and legal custodian of the child or to have visitation rights with respect to the child or to be a person other than a parent of the child who has custody or visitation rights with respect to the child (ORC 3127.23(A)(3)). Not Applicable The following person(s): _____

(Name of person or agency)

Address City/State/Zip

The information above is true, complete, and accurate to the best of my knowledge. I understand that knowingly providing false information in this document may result in a contempt of court finding against me which could result in a jail sentence and fine, or criminal penalties under R.C. 2921.13.

Your Signature

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

Plaintiff/Petitioner 1

v./and

Defendant/Petitioner 2

Case No. _____

Judge _____

Magistrate _____

Instructions: Check local court rules to determine when this form must be filed.
This affidavit is used to disclose health insurance coverage that is available for children. It is also used to determine child support. It must be filed if there are minor children of the relationship. **If more space is needed, add additional pages.**

STATEMENT OF HEALTH INSURANCE

This statement is made by _____
(Print Your Name)

_____ **Your Name** _____ **Other Parent**

Are your child(ren) currently enrolled in a low-income government-assisted health care program (Healthy Start/Medicaid)?

Yes No

Yes No

Are you enrolled in an individual (non-group or COBRA) health insurance plan?

Yes No

Yes No

Are you enrolled in a health insurance plan through a group (employer or other organization)?

Yes No

Yes No

If you are not enrolled, do you have health insurance available through a group (employer or other organization)?

Yes No

Yes No

Does the available insurance cover primary care services within 30 miles of the child(ren)'s home?

Yes No

Yes No

_____ **Your Name** _____ **Other Parent**

Under the available insurance, what would be the annual premium for a plan covering you and the child(ren) of this relationship (not including a spouse)?

\$ _____

\$ _____

Under the available insurance, what would be the annual premium for a plan covering you alone (not including children or spouse)?

\$ _____

\$ _____

If you are enrolled in a health insurance plan through a group (employer or other organization) or individual insurance plan, which of the following people is/are covered:

Yourself?

Yes No

Yes No

Your spouse?

Yes No

Yes No

Minor child(ren) of this relationship?

Yes No

Yes No

Number _____

Number _____

Other individuals?

Yes No

Yes No

Number _____

Number _____

Name of group (employer or organization) that provides health insurance

Address

Phone number

STATEMENT OF TRUTH

The information above is true, complete, and accurate to the best of my knowledge. I understand that knowingly providing false information in this document may result in a contempt of court finding against me which could result in a jail sentence and fine, or criminal penalties under R.C. 2921.13.

Your Signature

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	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: _____

