

IN THE DISTRICT COURT OF JOHNSON COUNTY, KANSAS

\_\_\_\_\_) )  
Party Name ) )  
vs. ) ) Case No. \_\_\_\_\_ )  
\_\_\_\_\_) ) )  
Party Name ) ) Division No. \_\_\_\_\_ )

**SHORT FORM DOMESTIC RELATIONS AFFIDAVIT**  
**OF \_\_\_\_\_ (name)**

To be used **ONLY** with post-judgment Motions to Establish or Modify Child Support.

1. Your Name: \_\_\_\_\_  
                                First                                Middle                                Last  
Residence: \_\_\_\_\_  
                                Address                                City                                ST                                Zip  
Year of Birth: \_\_\_\_\_ Last Four Digits of SSN: XXX-XX-\_\_\_\_\_ Phone \_\_\_\_\_

2. Name(s), last four digits of SSN(s), year of birth, and age(s) of minor children of this marriage/relationship:

Name	SSN	Year of Birth	Age
_____	XXX-XX-_____	XX-XX-_____	_____
_____	XXX-XX-_____	XX-XX-_____	_____
_____	XXX-XX-_____	XX-XX-_____	_____
_____	XXX-XX-_____	XX-XX-_____	_____

3. Name(s), last four digits of SSN(s), and year of birth of minor children of previous marriage/relationship(s) and facts as to custody and support payments paid or received, if any.

Name	Name of Custodian	SSN	YOB	Support Pd/Rec
_____	_____	XXX-XX-_____	XX-XX-_____	\$ _____
_____	_____	XXX-XX-_____	XX-XX-_____	\$ _____
_____	_____	XXX-XX-_____	XX-XX-_____	\$ _____
_____	_____	XXX-XX-_____	XX-XX-_____	\$ _____

4. You are employed by: Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, ST, Zip: \_\_\_\_\_

5. Monthly income:

- A. Wage Earner, Gross Income \$ \_\_\_\_\_
- B. Self-Employed, Gross Income \$ \_\_\_\_\_
- Reasonable Business Expense \$ \_\_\_\_\_
- Self-Employment Tax \$ \_\_\_\_\_

6. Work Related Child Care Expenses:

- A. Weekly Cost During Summer \$ \_\_\_\_\_ Name and Address of Provider \_\_\_\_\_  
\_\_\_\_\_
- B. Weekly Cost During School Year \$ \_\_\_\_\_ Name and Address of Provider \_\_\_\_\_  
\_\_\_\_\_

7.  \_\_\_\_\_  \_\_\_\_\_ provides Health Insurance for child(ren).

- Party Name \_\_\_\_\_ Party Name \_\_\_\_\_
- A. Name and Address of Health Insurance Plan: \_\_\_\_\_  
\_\_\_\_\_
- B. Person(s) insured on plan: \_\_\_\_\_  
 Monthly cost of health insurance: \$ \_\_\_\_\_  
 Monthly cost of dental insurance: \$ \_\_\_\_\_  
 Monthly cost of vision insurance: \$ \_\_\_\_\_  
 Monthly cost of drug prescription insurance: \$ \_\_\_\_\_  
 Increase cost of adding child(ren) to the plan: \$ \_\_\_\_\_

8.  \_\_\_\_\_  \_\_\_\_\_ claims child(ren) for income tax purposes.

- Party Name \_\_\_\_\_ Party Name \_\_\_\_\_
- You file taxes:  Single  Head of Household  Joint  Other

9. Child Support Adjustments requested (documentation to support requested adjustments must be brought to hearing):

- Long Distance Parenting Time Adjustment  Special Needs
- Parenting Time Adjustment  Income Tax Adjustment
- Agreement Past Minority  Overall Financial Condition

10. Please bring the following documents to the hearing: ***Social Security numbers and dates of birth must be removed from the documents.***

- Current Pay Stub  Last Year's Tax Return including schedules
- W-2  Written Proof of Day Care Cost
- Written Proof of Insurance Costs

**I declare under penalty of perjury under the laws of the state of Kansas that the foregoing is true, correct and complete.**

Executed on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Name (Print): \_\_\_\_\_  
Signature: \_\_\_\_\_