



FINANCIAL DECLARATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHILD SUPPORT
SFN 1531 (8-2023)

This declaration will help you present detailed information for use in determining the correct amount of child support to be ordered based on the North Dakota Child Support Guidelines. (N.D. Administrative Code ch. 75-02-04.1).

Complete the first five-pages of the Financial Declaration and every data sheet that applies to your financial situation. Return the completed financial declaration and data sheets, along with the required attachments via mail or email.

Child Support
PO Box 7190
Bismarck ND 58507-7190
childsupport@nd.gov

PERSONAL BACKGROUND

Name	Last Four Digits of SSN	Year of Birth
Education (list degrees held)		

List the names and dates of birth of your biological or adopted children who **do not** live with you. Include the name of the person with whom they reside and their relationship to the child.

Name of Child	Date of Birth	Name of Individual Living With	Relationship

List the names and dates of birth of your biological or adopted children who live with you.

Name of Child	Date of Birth	Name of Child	Date of Birth

If you have a court order for split, equal or partial residential responsibility (custody) or parenting time (visitation) you must complete Data Sheet A.

If you have an adopted child, is the adoption subsidized? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Individual Receiving Subsidy Payment	Monthly Amount

EMPLOYMENT

Are you currently employed?

☐ Yes ☐ No

If you are unemployed, you must complete Data Sheet B.

If you are self-employed, you must complete Data Sheet C.

If you are or have been in the military and have received military compensation or veterans' benefits, you must complete Data Sheet D.

If you have other income such as Workers' Compensation, Social Security, Railroad, other disability, or retirement payments, you must complete Data Sheet E.

If employed, you must attach:

- ☐ Most recent federal income tax return, including W-2s, 1099s, and all schedules.
- ☐ Year-end or final paystub from each employer who gave you a W-2 form.
- ☐ Year-to-date paystub from each employer for the current year.

If you have more than one employer, answer the questions in this section based on your primary job. Then attach additional pages for each of your other jobs.

Are you currently under any medical restrictions that limit your ability to work?

☐ Yes - Describe restrictions: ☐ No

You must attach:

- ☐ Current medical statement confirming any work restrictions, to be considered.

CURRENT EMPLOYER

Employer Name

Address

City

State

ZIP Code

Employer Telephone Number

Date Employment Started

Occupation

Brief Job Description

Rate of Pay (complete the option that best describes your situation)

Pay Cycle Type	Wage Amount	Hours	Overtime Amount	Hours
Hourly				
Monthly				
Annually				

Number of Pay Periods (check one)

☐ Weekly ☐ Monthly ☐ Semimonthly 24-per year (paid twice per month) ☐ Biweekly 26 per year (paid every two weeks)

☐ Other (specify): _____

Overtime

Regarding overtime, it will be included unless shown to be atypical. (Atypical means not normal for a period of time). If you have atypical overtime, please provide verification, such as paystubs and a letter from your employer.

Tips

Tips Amount	Per
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Commissions

Commission Amount	Per
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Bonuses

Did you receive any bonuses during the past three (3) calendar years?

☐ Yes - Answer below: ☐ No

Year	Amount	Reason

Do you expect to receive a bonus during the current calendar year?

☐ Yes ☐ No (specify reason): _____

Employee Benefits

Describe the benefits provided to you by your employer and the annual value of each benefit.
Examples include accrued vacation and sick leave, health insurance, employer retirement contributions, etc.

Benefit Provided	Annual Value

In-Kind Income

Describe any in-kind income provided to you by your employer and the annual value of the in-kind income. (In-kind income means you are allowed to use your employer's property, or you are being provided with services at no charge or less than the usual charge). Examples include housing allowance or the use of living quarters, or being provided with transportation, groceries, or cell phone.

In-Kind Income Received	Annual Value

If you have insurance and/or out of pocket medical expenses for the child, you must complete Data Sheet F.

Employee Expenses

Union Dues per Month	Name of Union
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Are unions dues required as a condition of employment?
☐ Yes ☐ No

List Each Professional/Occupational License you Hold	Is the license required as a condition of employment?	Annual Fee	Is fee covered or reimbursed by employer?
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

You must attach:

☐ **Proof that union dues are required as a condition of employment.**

☐ **Proof from your employer of expenses, licensure requirements and fees.**

Are you required, **as a condition of employment**, to contribute to a retirement plan?
☐ Yes - Answer below: ☐ No

Monthly Contribution	OR	Percentage of Gross Income %
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You must attach:

☐ **Proof that contributions to a retirement plan are required as a condition of employment.**

Do you have out-of-pocket expenses for special equipment or special clothing required as a condition of your employment?
(Examples: steel-toed boots, fire-resistant clothing, uniforms)

☐ Yes - Answer below: ☐ No

Item	Annual Out-of-Pocket	Amount Reimbursed

Do you have out-of-pocket expenses for lodging when you must travel as a condition of your employment, and are you reimbursed for these lodging expenses?

☐ Yes ☐ No - Answer below:

Number of Overnights in the Last Calendar Year	Number of Overnights in the Current Calendar Year-to-Date
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Are you required, as a condition of employment, to use your personal vehicle to drive **between work locations**, and are you reimbursed for these mileage expenses? (This does not include driving between your home and your work)

☐ Yes ☐ No - Answer below:

Number of Miles Driven in the Last Calendar Year	Number of Miles Driven in the Current Calendar Year-to-Date
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You must attach:

☐ **Proof of expenses for employment-related special equipment, clothing, lodging or mileage for driving between work locations, and that expenses are a condition of employment.**

INCARCERATION

Are you currently physically confined to a prison, jail, or other correctional facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes - Are you eligible for work release? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been released from incarceration within the past six months? <input type="checkbox"/> Yes-Date of Release: _____ <input type="checkbox"/> No	

COMMENTS

Provide any other information that you think would help Child Support understand your situation or to supplement answers given above, including any factors that affect you ability to work:

I declare, under penalty of perjury under the law of North Dakota, that the foregoing is true and correct.

Date Signed	City of	State of
Printed Name		
Signature		

DATA SHEET A: RESIDENTIAL RESPONSIBILITY (CUSTODY)

EQUAL

Equal residential responsibility means each parent, **by court order**, has residential responsibility for the child or all children for an equal amount of time.

Do you and the other parent have equal residential responsibility for your children?

☐ Yes ☐ No

SPLIT

Split primary residential responsibility means that you and the other parent have more than one child in common and you and the other parent each have primary residential responsibility for at least one child.

Do you and the other parent have split primary residential responsibility for your children?

☐ Yes ☐ No

PARTIAL EQUAL

Partial equal residential responsibility means that equal residential responsibility is court ordered for some but not all the children and an obligation must be calculated for each parent for whom the other parent has primary residential responsibility plus the children for whom the parents have equal residential responsibility.

If you and the other parent have partial equal residential responsibility for your children, please provide information regarding your court order and residential responsibility arrangement.

PARENTING TIME (VISITATION)

Does a court order specify when you have parenting time with your children and the annual total exceeds 100 overnights?

☐ Yes - Answer below: ☐ No

Provide the annual total number of court-ordered parenting time overnights.

Name of Child	Total Annual Number of Overnights

DATA SHEET B: UNEMPLOYMENT INFORMATION

You must attach:

☐ Unemployment compensation benefits award letter or other documentation of amounts received.☐ Most recent federal income tax return, including W-2s,1099s, and schedules.☐ Year-end or final paystub from each employer who gave you a W-2 form.

Last Employer Name

Address

City

State

ZIP Code

Job Title/Occupation

Date You Became Unemployed

Reason for Unemployment

Is your unemployment seasonal?

☐ Yes ☐ No

Did you receive severance pay when you became unemployed?

☐ Yes - Amount Received: ☐ No

Have you received unemployment compensation in the past 36 months?

☐ Yes - Answer below: ☐ No

Weekly Compensation Amount

Date Compensation Began

Date Compensation Ended

Work History

Describe other jobs you have had in the past, aside from your last employer.

DATA SHEET C: SELF-EMPLOYMENT INCOME

You must attach:

- ☐ Business and personal federal income tax returns, including all schedules, for the last five years including, as applicable, IRS Forms 1040, 1065, 1120, and 1120S.
- ☐ If you do not have income tax returns, provide profit and loss statements for the last five years.

Note: If you have more than one self-employment activity, please answer the questions in this section based on your primary self-employment activity. Then attach additional pages to provide the same kind of information for each of your other self-employment activities.

Select the Structure of Business and the Percentage of Ownership

Structure of Business	Percentage of Ownership	Structure of Business	Percentage of Ownership
<input type="checkbox"/> Sole Proprietorship		<input type="checkbox"/> S Corporation	%
<input type="checkbox"/> Partnership	%	<input type="checkbox"/> C Corporation	%

Name of Business Entity		Business Telephone Number	
Address	City	State	ZIP Code
How long has this business been in existence? Years: Months:		Tax Identification Number(s)	
Type of Business <input type="checkbox"/> Farming <input type="checkbox"/> Service <input type="checkbox"/> Retail Sales <input type="checkbox"/> Wholesale Sales <input type="checkbox"/> Manufacturing <input type="checkbox"/> Other (describe): _____			
Description of Business Activity (e.g., type of service provided, type of item sold, etc.)			

List the household members who work in this business, the wage/salary paid, and the job duties

Name of Household Member	Wages/Salary	Job Duties

Currently Deferred Income

Amount Per Year

Receipt of Previously Deferred Income

Amount Per Year	Was this treated as income to you at the time it was deferred? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount Previously Included
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Gains

Amount Per Year	Describe Transaction Resulting in Gains
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DATA SHEET D: MILITARY SERVICE / VETERAN'S BENEFITS

Are you currently in the military?

☐ Yes - Answer below: ☐ No

Branch	Rank	Occupation
Years of Service	Duty Station	

Provide the monthly payments and allowances you receive

Payment Type	Monthly Amount
Base Pay	
Basic Allowance for Housing (BAH)	
Basic Allowance for Subsistence (BAS)	
Other	

You must attach:

- ☐ Year-to-date Leave and Earnings Statement for the current year.
☐ Final Leave and Earnings Statement for most recent tax year.

Veterans' Benefits

Are you receiving veterans' pension or disability benefits?

☐ Yes - Answer below: ☐ No

Monthly Payment	Date Payments Began	Percentage (if disabled) %
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Does the child receive benefits resulting from your own claim for benefits?

☐ Yes - answer below: ☐ No

Name of Child	Type of Benefit	Monthly Amount

You must attach:

- ☐ Veterans' pension or disability benefits award letter.

Military Retirement Benefits

Are you receiving military retirement benefits?

☐ Yes - Answer below: ☐ No

Monthly Payment	Date Payments Began
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You must attach:

- ☐ Military retirement award letter.

DATA SHEET E: OTHER INCOME

Workers' Compensation

Are you now receiving, or did you receive workers' compensation wage replacement payments?

☐ Yes - Answer below: ☐ No

Weekly Payment	Date Payments Began	Date Payments Ends
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You must attach:

☐ **Workers' compensation benefits award letter.**

Social Security Payments

Are you receiving Social Security Disability Income (SSDI) payments?

☐ Yes - Answer below: ☐ No

Full Monthly Payment Before Deductions	Date Payments Began
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Does your child receive benefits resulting from your own claim for benefits?

☐ Yes - Answer below: ☐ No

Name of Child	Type of Benefit	Monthly Amount

Are you receiving Social Security-Supplemental Security Income (SSI) payments?

☐ Yes ☐ No

Are you receiving Social Security retirement payments?

☐ Yes - Answer below: ☐ No

Full Monthly Payment Before Deductions	Date Payments Began
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Are you receiving Social Security survivor's payments?

☐ Yes - Answer below: ☐ No

Monthly Payment	Date Payments Began
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You must attach:

☐ **Social Security Disability Income (SSDI) benefits award letter.**

☐ **Social Security Income (SSI) benefits award letter.**

☐ **Social Security Retirement benefits award letter.**

☐ **Social Security Survivor's benefits award letter.**

DATA SHEET E: OTHER INCOME (continued)

Railroad Retirement Board Payments

Are you receiving total and permanent disability payments from the railroad retirement board?
☐ Yes - Answer below: ☐ No

Full Monthly Payment Before Deductions	Date Payments Began
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Are you receiving occupational disability payments from the railroad retirement board?
☐ Yes - Answer below: ☐ No

Full Monthly Payment Before Deductions	Date Payments Began
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Are you receiving retirement payments from the railroad retirement board?
☐ Yes - Answer below: ☐ No

Full Monthly Payment Before Deductions	Date Payments Began
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You must attach:
☐ Railroad retirement board benefits award letter.

Other Disability or Retirement Payments

Are you receiving any disability, retirement, or pension payments not included above?
☐ Yes - Answer below: ☐ No

Source of Payment	Monthly Payment	Date Payments Began
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Additional Sources of Income

Source of Income	Amount Per Year
Dividends and Interest	
Annuity Income	
Trust Income	
Rental Income	
Mineral Lease Income	
Income from Royalties	
Spousal Support (Alimony) Payments Received	
Gifts and Prizes (exceeding \$1000/year)	
Refundable Tax Credits	
Gains	
Specify Any Other Income	

DATA SHEET F: INSURANCE AND MEDICAL EXPENSES

Do you have <u>access</u> to insurance coverage for your children?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
If coverage is or would be available, are you currently enrolled in the health insurance plan?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
If you are not currently eligible for coverage, on what date will you be eligible?			
Select Plan Currently Enrolled In			
<input type="checkbox"/> Single <input type="checkbox"/> Single plus Dependent <input type="checkbox"/> Family <input type="checkbox"/> Child/Children Only			
Insurance Company			Telephone Number
Address		City	State ZIP Code
Name of Policyholder		Group Number	Policy Number
Persons Covered			Effective Date

What is the cost to you for all available health insurance plans?

Plan	Cost	Per	Plan	Cost	Per
Single			Family		
Single + Dependent			Child Only		

You must attach:

☐ A copy of the front and back of any insurance cards

Do you currently have dental insurance for your children?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Persons Covered	Effective Date

DATA SHEET F: INSURANCE AND MEDICAL EXPENSES (continued)

What is the cost to you for all available dental plans?

Plan	Cost	Per
Single		
Single + Dependent		

Plan	Cost	Per
Family		
Child Only		

Do you currently have vision insurance for your children?

☐ Yes ☐ No

Persons Covered	Effective Date

What is the cost to you for all available vision plans?

Plan	Cost	Per
Single		
Single + Dependent		

Plan	Cost	Per
Family		
Child Only		

Annual amount of out-of-pocket medical expenses you pay for the children for whom support is being determined

Name of Child	Annual Amount

Is it reasonably likely that similar expenses will continue?

☐ Yes - Describe expenses below: ☐ No

You must attach:

☐ Proof of out-of-pocket actual medical expense payments made by you. (Example: detailed billing statements)