**White Earth Nation Child Support**

**IV-D Program (WEN CSP)**

**PO Box 387, White Earth, MN 56591 Tel (218) 935-3512 Fax (833) 859-0834**

**FINANCIAL STATEMENT**

**WEN CSP Case Number**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SSN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY, STATE, ZIP

**TELEPHONE NUMBER**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MESSAGE PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF SELF EMPLOYED, EMPLOYER ID** # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE PROVIDE DOCUMENTATION (EARNINGS, 3 YEARS OF TAX RECORDS)**

**EMPLOYER NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYER ADDRESS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYER PHONE NUMBER**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOW LONG HAVE YOU WORKED THERE?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OCCUPATION/JOB TITLE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IS THIS A TRIBAL EMPLOYER?** YES/ NO

WAGES: $ \_\_\_\_\_\_\_\_\_\_\_\_ HOURLY WEEKLY MONTHLY YEARLY SEASONAL

**HEALTH INSURANCE AVAILABLE?** YES/NO

**AMOUNT OF INSURANCE PAID (PROVIDE DOCUMENTATION) $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** YEARLY MONTHLY OTHER

**NAME OF INSURANCE COMPANY**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE COMPANY ADDRESS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COVERAGE TYPE**: (CIRLCE ALL THAT APPLY)

HOSPITALIZATION MAJOR MEDICAL PRESCRIPTION DENTAL VISION OTHER

**LIST ALL WHO ARE COVERED UNDER YOUR INSURANCE POLICY:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IS THERE AN ORDER ESTABLISHED FOR CUSTODY AND/OR PARENTING TIME?**

**WHAT COURT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE EXPLAIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AMOUNT COURT ORDERED CHILD SUPPORT YOU PAY FOR ANY OTHER CHILDREN:**

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AMOUNT COUNTY AMOUNT COUNTY

**LIST ANY OTHER INCOME YOU RECEIVE:**

$ \_\_\_\_\_\_\_\_\_\_\_\_\_ FREQUENCY\_\_\_\_\_\_\_\_\_\_\_\_\_ SOURCE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

$ \_\_\_\_\_\_\_\_\_\_\_\_\_ FREQUENCY\_\_\_\_\_\_\_\_\_\_\_\_\_ SOURCE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ARE YOU CURRENTLY RESPONSIBLE FOR ANY CHILD CARE EXPENSES**? YES/ NO

IF ‘YES’, WHAT ARE THE EXPENSES? $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FREQUENCY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE PROVIDE DOUMENTATION OF CHILDCARE EXPENSES PAID.**

**MONTHLY PAYMENTS**:

$ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOUSE PAYMENT/RENT $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INSURANCE

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FOOD $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TRANSPORTATION NEEDS

$ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ELECTRIC $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AUTO LOANS

$ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GAS $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OTHER

$ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WATER

$ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE

ARE THERE ANY OTHER BIOLOGICAL CHILDREN RESIDING WITH YOU THAT YOU ARE FINANCIALLY RESPONSIBLE FOR THAT YOU DO **NOT** HAVE IN COMMON WITH THE OTHER PARENT IN THIS CHILD SUPPORT CASE?

YES/NO IF ‘YES’, HOW MANY? \_\_\_\_\_\_\_\_\_\_\_

**INITIALS OF CHILD(REN)**

Child(ren)\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Child(ren)\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_

Child(ren)\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Child(ren)\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_

**ATTACH A COPY OF YOUR PAY STUBS FOR THE LAST THREE (3) MONTHS TO THIS FORM OR ANY OTHER PROOF OF INCOME.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE DATE**