



# Iowa Department of Human Services

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April 8, 2016

## GENERAL LETTER NO. 10-H-AP-3

ISSUED BY: Bureau of Child Support Recovery  
Division of Field Operations

SUBJECT: Employees' Manual, Title 10, Chapter H, **DETERMINING CHILD SUPPORT OBLIGATIONS APPENDIX**, Title page, revised; Contents (page 1), revised; pages 1 through 15, revised; and the following forms:

470-0204 *Financial Statement*, revised  
470-2154 *Request to Complete Financial Statement*, unchanged  
470-2639 *Request for Financial Statement*, revised  
470-2640 *Child Support Guidelines Worksheet*, revised  
470-2870 *Foster Care Financial Statement*, revised  
470-2950 *Child Support Guidelines Worksheet Cover Letter*, revised  
470-3515 *Verification of Social Security Information*, revised  
RC-0133 *Determining Medical Support Orders in the Establishment and Modification Processes Desk Aid*, new

### Summary

This chapter is revised to:

- ◆ Correct the pages that reference how to serve payors and payees in child support actions.
- ◆ Add updates to the policy and the Guidelines Application instructions to reflect recent changes to the Iowa Child Support Guidelines.
- ◆ Reflect the Department's current manual standards.
- ◆ Add forms used in the guidelines process.
- ◆ Add links to the Internal Revenue Service's website to obtain the most recent versions of IRS forms.

### Effective Date

Immediately.

## **Material Superseded**

This material replaces the entire Chapter H, Appendix from Employees' Manual, Title 10, which includes the following pages:

<u>Page</u>	<u>Date</u>
Title page	April 22, 2003
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3, 4	April 22, 2003
470-2639	2/2002
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470-2640	8/2000
470-2870	6/2002
7, 8	April 22, 2003
470-2950	2/2002
9, 10	April 22, 2003
470-3515	09/01
470-3935	04/03
11, 12	April 22, 2003
IRS-2441	2002
IRS Schedule C	2002
13, 14	April 22, 2003
IRS Schedule F	2002
IRS Schedule SE	2002
15	April 22, 2003

## **Additional Information**

Refer questions about this general letter to your regional collections administrator.

Revised April 8, 2016

Employees' Manual  
Title 10  
Chapter H Appendix

# **DETERMINING CHILD SUPPORT OBLIGATIONS**

## **APPENDIX**



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### 470-0204, Financial Statement

Purpose	Use form 470-0204, <i>Financial Statement</i> , to request the parents' financial information.
Source	<p>Generate this form by making the following entries on the respective process screens:</p> <ul style="list-style-type: none"><li>◆ ADMIN: Enter a "Y" in the GENERATE NOTICES field on the ADMIN screen to generate this form for the first time, or an "R" to regenerate it.</li><li>◆ ADPAT: Enter a "Y" in the GENERATE NOTICES field on the ADPAT screen to generate this form for the first time, or an "R" to regenerate it.</li><li>◆ PATEST: Enter a "Y" in the GEN FORMS field on the PATEST2 screen to generate this form for the first time, or an "R" to regenerate it.</li><li>◆ REVIEW: Enter a "Y" in the NOI field on the REVIEW1 screen to generate this form for the first time, or an "R" to regenerate it.</li><li>◆ ADMOD: Enter a "Y" in the NOI field on the ADMOD1 screen to generate this form for the first time, or an "R" to regenerate it.</li></ul>
Completion	<p>Complete this form when you need to compute the child support obligation.</p> <p>If generated from the ADMIN, ADPAT, PATEST2, REVIEW1, or ADMOD1 screen, ICAR automatically enters all of the data in the heading of this form. If generated manually, you must enter all of the data. Each parent completes the remainder of this form.</p>
Distribution	Personally serve, by certified mail or through a sheriff or private process server, one copy of this form with the accompanying establishment or modification documents upon the payor (or the alleged father if appropriate).

| Personally serve, by certified mail or through the sheriff or private process server, one copy of this form with accompanying modification documents upon the payee (not the caretaker, if the other parent is not the caretaker).

| Mail one copy of this form with accompanying establishment documents by first-class mail to the payee (not the caretaker if the other parent is not the caretaker).

Data ICAR enters all of the information on the form. You must enter the information for manually generated forms:

- | ♦ Payor's/alleged father's name
- | ♦ Payee's or caretaker's name
- | ♦ Third party's name (if applicable)
- | ♦ Children's names
- | ♦ Date generated (current date in MM/DD/CCYY format)
- | ♦ Docket number
- | ♦ ICAR number
- | ♦ Worker ID
- | ♦ County name where document is filed

CSC No: \_\_\_\_\_  
Party Name: \_\_\_\_\_  
Dependents: \_\_\_\_\_  
\_\_\_\_\_

**FINANCIAL STATEMENT**

CHILD SUPPORT RECOVERY UNIT  
IOWA DEPT OF HUMAN SERVICES

DATE: \_\_\_\_\_

Docket No: \_\_\_\_\_  
County: \_\_\_\_\_

Worker ID: \_\_\_\_\_  
Phone: \_\_\_\_\_

**COMPLETE THIS FORM USING BLACK INK AND RETURN IN 10 DAYS**

**Because this form becomes a public record, do not list any personal information such as:**

**► the name of employer(s), or ► addresses, or ► social security numbers, or ► telephone numbers**

I am currently.....  Employed full-time  Employed part-time  Self-employed  Unemployed

Job Title or Occupation \_\_\_\_\_

I am paid: .....  weekly  bi-weekly (every other week)  twice a month  monthly

My paychecks are: .....  the same each pay period  different each pay period

The amount of my last paycheck (before deductions) was:.....\$

**(Attach your last three pay stubs. If self-employed, attach your last three income tax returns and all schedules).**

I get income from other sources (not FIP or TANF benefits) .....  YES  NO

**Attach proof of other income such as pay stubs, award letters, or tax returns**

**Check All That Apply:**

Another Job \$            weekly  bi-weekly  twice a month  monthly

Unemployment \$            weekly  bi-weekly  twice a month  monthly

Worker's Compensation \$            weekly  bi-weekly  twice a month  monthly

Pension/Retirement \$            weekly  bi-weekly  twice a month  monthly

Veteran's Benefits \$            monthly

Supplemental Security Income (SSI) \$            monthly

Social Security Disability (SSD) or Social Security Retirement (SSR)

\$            monthly and benefits are for:  myself  my spouse  my children

Other (please specify) \_\_\_\_\_

\$            weekly  bi-weekly  twice a month  monthly

List the cost for health or dental plans that are available to you **even if you are not currently enrolled:**

**Attach verification that shows all of the plans available to you, and the costs for BOTH family and single coverage.** If a health benefit plan is ordered, the cost of the health insurance premium for the child(ren) is added to the support obligation and shared between you and the other parent. If you want to carry health insurance for the child(ren) through a stepparent you may provide that plan information.

Family Health Insurance.....\$            weekly  bi-weekly  twice a month  monthly

Single Health Insurance.....\$            weekly  bi-weekly  twice a month  monthly

Family Dental Insurance.....\$            weekly  bi-weekly  twice a month  monthly

Single Dental Insurance.....\$            weekly  bi-weekly  twice a month  monthly

I currently carry a .....  Single Health Plan  Family Health Plan

I currently carry a .....  Single Dental Plan  Family Dental Plan

Health insurance is not available.

I am currently married .....  YES  NO

List the amounts you pay and **attach proof of the following deductions.**

**Union Dues** \$ [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  weekly  bi-weekly  twice a month  monthly

You may only receive a mandatory pension deduction if **you do not contribute to Social Security.**

**Mandatory Pension** \$ [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  weekly  bi-weekly  twice a month  monthly

**Mandatory Occupational License Fees** \$ [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  yearly  other: \_\_\_\_\_ (Enter a time period)

Who pays your fees?  I do.  My employer does.

If you pay the fees, do you deduct them on your tax return as a business expense?  YES  NO

You may receive credit for other court ordered child support, medical support, or alimony you are paying.

I pay child support for other children of mine:

.....  to the Iowa Collection Services Center  to the Clerk of Court  to another state

I pay medical support for other children of mine:

.....  to the Iowa Collection Services Center  to the Clerk of Court  to another state

I pay alimony:

.....  to the Iowa Collection Services Center  to the Clerk of Court  to another state

***If you make payments through the clerk of court or another state, attach a copy of the court order and proof of payments. CSRU has records of payments made to the Iowa Collection Services Center.***

I have other children with no court order for support.....  YES  NO

***(Include other children for whom you receive payments. Do not include stepchildren.)***

Child's Name	Date of Birth	Child's Name	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____

***You must provide proof such as: 1) birth certificate and marriage certificate, or 2) paternity affidavit, or 3) Court or Administrative Order. CSRU has records of paternity affidavits approved by the State of Iowa.***

**FOR PAYEES (person owed support or for court-ordered joint physical care, either parent) ONLY:**

I have child care expenses while I am at work.....  YES  NO

***(Attach proof of payments such as a letter from your day care provider or a copy of the Child and Dependent Care Expenses tax form.)***

If yes, list the amount \$ [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  weekly  bi-weekly  twice a month  monthly

**FOR PAYORS (person paying support) ONLY:**

The children in this case stay overnight at least 128 times per year with me.....  YES  NO

***This must be court ordered and a copy of the order must be attached. If the court ordered equally shared physical care, Extraordinary Visitation Credit does not apply.***

**SIGNATURE**

**I certify under penalty of perjury (punishment for lying) and under the laws of the State of Iowa that the above financial information I have given is true and correct. I understand that you may use this information in an action to establish or modify support for my children. I agree to accept service of all documents related to this action by first class mail. I further agree to inform your office of any change of address.**

SIGN HERE: \_\_\_\_\_ DATE: \_\_\_\_\_



CSC No: \_\_\_\_\_  
 Party Name: \_\_\_\_\_  
 Dependents: \_\_\_\_\_  
 \_\_\_\_\_

**FINANCIAL STATEMENT**  
 CHILD SUPPORT RECOVERY UNIT  
 IOWA DEPT OF HUMAN SERVICES

Docket No: \_\_\_\_\_  
 County: \_\_\_\_\_  
 Worker ID: \_\_\_\_\_  
 Phone: \_\_\_\_\_

DATE: \_\_\_\_\_

**OTHER HOUSEHOLD INCOME**

My spouse/partner is currently..... Employed full-time Employed part-time Self-employed Unemployed

Job Title/Occupation: \_\_\_\_\_

Spouse/Partner is paid: weekly bi-weekly twice a month monthly

The amount of each paycheck (before deductions) is: \$       .

**MY MONTHLY EXPENSES**

Monthly House Payment or Rent:..... \$       .

Monthly Utilities (Such as heat, gas, water, and electric):..... \$       .

Monthly Cost of Meals or Food:..... \$       .

Monthly Telephone/Cell Phone Costs: ..... \$       .

Monthly Clothing Costs:..... \$       .

Monthly Cable T.V. Costs: ..... \$       .

Monthly Car Expenses (Not the amount of your car loan payment): ..... \$       .

Monthly Internet Service: ..... \$       .

Other expenses paid monthly:..... \$       .

Please specify other expenses: \_\_\_\_\_

There are other people who help pay my monthly expenses ..... YES NO  
 (Do not include the spouse/partner listed above).

If yes, list the amount they pay each month..... \$       .

**MY MONTHLY DEBTS/INSTALLMENT PAYMENTS**

For example: department stores, loan companies, banks, or auto loans  
 (If you need more space, please attach a separate sheet of paper.)

**Payable to/Item**

**Monthly Payment Amount**

**Balance Due**

_____	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
_____	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
_____	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>

**MY ASSETS**

Balance in Savings Account: .....\$

Name of Bank: \_\_\_\_\_

Balance in Checking Account: .....\$

Name of Bank: \_\_\_\_\_

Real Estate Value: .....\$

Balance owed on real estate:.....\$

Stocks: .....\$

Bonds:.....\$

**Vehicles:**

Type: \_\_\_\_\_ Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_

Type: \_\_\_\_\_ Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_

**SIGNATURE**

**I certify under penalty of perjury (punishment for lying) and under the laws of the State of Iowa that the above financial information I have given is true and correct. I understand that you may use this information in an action to establish or modify support for my children. I agree to accept service of all documents related to this action by first class mail. I further agree to inform your office of any change of address.**

SIGN HERE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Request for Additional Financial Information**

Date: \_\_\_\_\_  
Case Number: \_\_\_\_\_  
Worker ID: \_\_\_\_\_

Child Support Recovery Unit

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

Phone: \_\_\_\_\_

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

We need more financial information from you to set your child support. The amount of your child support is based on the Iowa Supreme Court guidelines.

After you fill out the form, send it to the office listed at the top of the page. Please return the form within 10 days of the date of this request.

We may provide a copy of this form to the other parent. We may file this information with the court. If so, the information will become public record.

If you have questions about filling out this form, please contact your local office (see address and phone number above).

Iowa Department of Human Services

REQUEST TO COMPLETE FINANCIAL STATEMENT

Date: \_\_\_\_\_

Case Number: \_\_\_\_\_

Dependents:

You were previously ordered to pay child support for the above-named dependents who are now or were recently in foster care placement. This child support obligation was established by court order # \_\_\_\_\_ filed in \_\_\_\_\_ County, \_\_\_\_\_.

The amount of child support that was previously established for you to pay continues to be in effect for the time period that the child(ren) are in foster care. Your child support payments are assigned to the State and used by the Department of Human Services to offset the cost of the foster care placement.

The Foster Care Recovery Unit, which is a part of the Child Support Recovery Unit, is attempting to obtain an order for support from the other parent for the period of time that the child(ren) are in foster care. **Your financial information will be used in determining the amount of the support order for the other parent and will not affect your child support obligation.** The current child support guidelines in effect in the state of Iowa require that we consider the income of both parents in determining the amount of the order.

Provide information that is current and correct to the best of your knowledge. If necessary, you may provide additional information on a separate sheet. You must provide proof of your income and any deductions that you report on the financial statement. Proof of income and allowable deductions may be a copy of your state or federal income tax return, W-2 statements, pay stubs, signed statements from your employer or other source of income, or clerk of court payment records.

***Please return the completed financial statement to the Foster Care Recovery Unit within 10 days of the date of this request.*** A return envelope is enclosed for this purpose.

If you have questions about this letter or the financial statement, please contact the office indicated below.

\_\_\_\_\_

Foster Care Recovery Unit

Phone:

### 470-2154, Request to Complete Financial Statement

Purpose	Use form 470-2154, <i>Request to Complete Financial Statement</i> , with form 470-2870, <i>Foster Care Financial Statement</i> , in the ADMIN process, to inform the payor with a prior support order that the prior order remains in effect. This form also explains that this payor's financial information will be used to determine the other parent's child support obligation.
Source	Because this form is not used frequently, this form is not generated from the ADMIN screen. Generate it from the FORMVIEW screen.
Completion	Complete this form when the payor has a prior support order including the child in foster care.  You must enter all of the data into this form.
Distribution	Personally serve, by certified mail or through the sheriff or private process server, one copy of this form with the <i>Foster Care Financial Statement</i> upon the payor who is already ordered to pay support.
Data	Worker enters all of the following information on the form: <ul style="list-style-type: none"><li>◆ Date generated (current date in MM/DD/CCYY format)</li><li>◆ ICAR number</li><li>◆ Payor's name and address</li><li>◆ Children's names</li><li>◆ Court order number</li><li>◆ County and state where prior order is being filed</li><li>◆ Worker name, address, and telephone number</li></ul>

### 470-2639, Request for Financial Statement

Purpose	<p>Use form 470-2639, <i>Request for Financial Statement</i>, in an establishment action to:</p> <ul style="list-style-type: none"><li>◆ Ask each parent to complete and return form 470-0204, <i>Financial Statement</i>, within ten days.</li><li>◆ Explain the use of the guidelines in determining child support obligations.</li><li>◆ Inform the parent of the consequences of not returning the <i>Financial Statement</i> in ten days.</li></ul>
Source	<p>Enter a "Y" in the GENERATE NOTICES field on the ADMIN or the ADPAT screen to generate this form for the first time, or an "R" to regenerate it.</p>
Completion	<p>Complete this form when you send the <i>Financial Statement</i> to the payor/alleged father and payee to enable you to compute the child support obligation.</p> <p>If you generate this form from the ADMIN or the ADPAT screen, ICAR automatically enters all of the data in the heading of the form. If you generate it manually, you must enter all of the data.</p>
Distribution	<p>Personally serve, by certified mail or through the sheriff or private process server, one copy of this form with form 470-3309, <i>Notice of Intent to Establish Paternity (and Support)</i>, or with form 470-1922, <i>Notice of Support Debt</i>, and accompanying documents upon the payor or the alleged father.</p> <p>Mail one copy of this form and accompanying documents to the payee (not the caretaker, if the other parent is not the caretaker) by first-class mail. For an interstate case, mail the payee's copy to the responding state.</p>

## REQUEST FOR FINANCIAL STATEMENT

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

Date: \_\_\_\_\_

Case Number: \_\_\_\_\_

Dependents: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Child Support Recovery Unit**

\_\_\_\_\_

\_\_\_\_\_

**Telephone:** \_\_\_\_\_

We are trying to get an order for paternity and/or support for the children listed above. Federal and state laws say that all support orders must be based on guidelines set in the state. We use guidelines set by the Iowa Supreme Court. The guidelines are based on both parents' income.

**What do I need to do?**

1. Fill out the attached Financial Statement and return it within 10 days. Iowa law says that when we ask for it, parents must give us this information. Enter your current financial information. If needed, put more information on a separate sheet. **If there is a recent change in your finances, show this on the financial statement.**

**Note: We may file your financial statement with the court, making it a public record. We may give a copy of your financial statement to the other parent during this action.**

2. Send us proof of how much you make and your deductions, such as:
  - A copy of your state or federal income tax return
  - W-2 statements
  - Pay stubs
  - Signed statements from your employer or other sources of income
  - Other state or clerk of court payment records
  - Verification of health insurance costs (single and family coverage amounts).

**You don't have to send proof of any FIP (welfare), food stamps, or Medicaid you get.** However, even if you get those benefits, you still have to fill out the form. If you don't, your income maintenance worker may lower or stop your FIP grant or Medicaid benefits. We may

also close your child support case. Please help us get an order based on your real financial situation.

### 3. Remember:

- Fill out the financial statement correctly. Sign it.
- Within 10 days from the date on this letter, return the financial statement and proof to the address listed on page 1.
- We need your information to figure the amount of child support. If we don't have your information, we may use median income or income for your last-known type of job. We may also check with your employer, government agencies or other income sources. We may also have to estimate your deductions.
- Report changes in your financial situation to our office.
- **None of the information in this form is meant to give you legal advice or change your rights.**
- **Our attorney acts only on behalf of the state in legal actions.**

If you have questions about how to fill out the financial statement, please contact the office listed on page 1.

### What if I disagree with this action?

Your rights and time frames for disagreeing with this action are listed in one of the following notices you got with this form:

- The Notice of Support Debt Chapter 252C,
- The Original Notice,
- The Notice of Intent to Establish Paternity and Support,
- The Notice to Mother of Intent to Establish Paternity and Support.

Returning a financial statement and proof of income **is not** a request for:

- A negotiation conference, or
- A court hearing, or
- An answer to a petition.

**Even if you don't respond, we can still try to get an order. After an order is entered, we will enforce it.**

Data

ICAR enters all of the information on the form. You must enter the information for manually generated forms:

- ◆ Date generated (current date in MM/DD/CCYY format)
- ◆ ICAR number
- ◆ Payee's name and address or responding state's IV-D agency name and address
- ◆ Payor's/alleged father's name and address
- ◆ Worker's name, ID, address and telephone number
- ◆ Children's names

**470-2640, Child Support Guidelines Worksheet**

Purpose	Use form 470-2640, <i>Child Support Guidelines Worksheet</i> , to inform each parent about the child support obligation.
Source	Generate this form from the guidelines application.
Completion	Complete this form after you gather the parent's financial information and after you calculate the child support obligation. Enter all necessary financial information into the guidelines application which performs the necessary calculations.
	To print this form from the guidelines application, click on the GUIDELINES tab. Select VIEW/PRINT GUIDELINES WORKSHEET or view/PRINT REDACTED GUIDELINES WORKSHEET.
Distribution	Send one copy each to the payor/alleged father and the payee by first-class mail with the cover letter.
Data	The form contains the following information: <ul style="list-style-type: none"><li>◆ Case number</li><li>◆ Docket numbers</li><li>◆ Dependents included in support order</li><li>◆ Names of payor/alleged father and payee</li><li>◆ Method used to determine income</li><li>◆ Income information and deductions</li><li>◆ Calculation used to determine guideline amount of child support</li><li>◆ Extraordinary visitation</li><li>◆ Deviation reason and amounts, if appropriate</li><li>◆ Recommended amount of current and accrued support</li><li>◆ Recommended medical support</li><li>◆ Changes in support obligation as children emancipate</li><li>◆ Qualified additional dependents (QADD)</li><li>◆ Comments</li></ul>

**CHILD SUPPORT GUIDELINES WORKSHEET**

Date: \_\_\_\_\_

Case No.: \_\_\_\_\_  
 Docket No.: \_\_\_\_\_

Dependents: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Custodial /Other Parent's Income

Noncustodial Parent Income

Method(s) Used to Determine Income

- ( ) Financial Statement/Verified Income
- ( ) Other Sources
- ( ) CSRU Median Income

Method(s) Used to Determine Income

- ( ) Financial Statement/Verified Income
- ( ) Other Sources
- ( ) CSRU Median Income

**I. ADJUSTED NET MONTHLY INCOME COMPUTATION**

	Custodial Parent*	Noncustodial Parent*
	(name)	(name)
A. Gross Monthly Income	\$ _____	\$ _____
B. Federal Income Tax	\$ _____	\$ _____
C. State Income Tax	\$ _____	\$ _____
D. Social Security and Medicare Tax / Mandatory Pension Deduction	\$ _____	\$ _____
E. Mandatory Occupational License Fees Deduction	\$ _____	\$ _____
F. Union Dues	\$ _____	\$ _____
G. Actual Medical Support Paid Pursuant to Court Order or Administrative Order in Another Order for Other Children, not the Pending Matter	\$ _____	\$ _____
H. Prior Obligation of Child Support and Spouse Support Actually Paid Pursuant to Court or Administrative Order	\$ _____	\$ _____
I. Qualified Additional Dependent Deductions	\$ _____	\$ _____
J. Actual Child Care Expense While Custodial Parent* is Employed, Less the Appropriate Income Tax Credit	\$ _____	\$ _____
K. Preliminary Net Income for Each Parent (Line A minus lines B through J for each parent.)	\$ _____	\$ _____
L. Cash Medical Support, if Ordered in this Pending Matter	\$ _____	\$ _____
M. Adjusted Net Monthly Income (Line K minus line L.) (Amount used to calculate the guideline amount of child support.)	\$ _____	\$ _____

\*In cases of joint physical care, use names only and designate both parents as custodial parents

**II. CALCULATION OF THE GUIDELINE AMOUNT OF SUPPORT** (If applicable.)

	<u>Custodial Parent</u>	<u>Noncustodial Parent</u>	<u>Combined</u>
A. Adjusted Net Monthly Income	\$ _____	+ \$ _____	= \$ _____
B. Proportional Share of Income (Also used for Uncovered Medical Expenses.)	_____ %	+ _____ %	= 100%
C. Number of Children for Whom Support is Sought			_____
D. Basic Support Obligation Using Only NCP's Adjusted Net Monthly Income (If low-income adjustment does not apply, enter N/A.)		\$ _____	
E. Basic Support Obligation Using Combined Adjusted Net Monthly Income (If low-income adjustment applies enter N/A; see rule 9.3(2) and grid in rule 9.14(2).)			\$ _____
F. Each Parent's Share of the Basic Support Obligation Using Combined Incomes (If low-income adjustment applies enter N/A.)	\$ _____	\$ _____	
G. NCP's Basic Support Obligation Before Health Insurance (NCP's amount from line F or low-income adjustment amount from line D.)		\$ _____	
H. Cost of Child(ren)'s Health Insurance Premium (Difference between family and single cost.)	\$ _____	\$ _____	
I. Health Insurance Add-On or Deduction from NCP's Obligation		+/- \$ _____	
J. Guideline Amount of Child Support for NCP (NCP's line G plus or minus NCP's line I.)		\$ _____	

**II. a. EXTRAORDINARY VISITATION CREDIT:**

(Complete only if noncustodial parent's court-ordered visitation exceeds 127 overnights per year.)

K. NCP's Basic Support Obligation Before Health Insurance (Amount from NCP's line G.)	\$ _____
L. Number of court-ordered visitation overnights with the noncustodial parent	_____
M. Extraordinary Visitation Credit Percentage	_____ %
N. Extraordinary Visitation Credit (Line K multiplied by Line M)	\$ _____
O. Guideline Amount of Child Support (After Credit for Extraordinary Visitation) (Line J minus line N; not less than \$30 for one child or \$50 for two or more children.)	\$ _____

**II. b. VARIANCE:**

Current Obligation: \$ \_\_\_\_\_ New Obligation: \$ \_\_\_\_\_ Variance: \_\_\_\_\_ %

**III. CALCULATION OF THE JOINT (EQUALLY SHARED) PHYSICAL CARE GUIDELINE AMOUNT OF CHILD SUPPORT** (If applicable)

**IV. Deviations:** (See attachment.)

Text	\$ _____
Text	\$ _____
Text	\$ _____
Total Deviations:	

**ADJUSTED NET MONTHLY INCOME COMPUTATION**

	Custodial Parent*	Custodial Parent*
	_____ (name)	_____ (name)
	_____	_____
K. Preliminary Net Income for Each Parent (Line A minus lines B through J for each parent.)	\$ _____	\$ _____
L. Cash Medical Support, if Ordered in this Pending Matter	\$ _____	\$ _____
M. Adjusted Net Monthly Income (Line K minus line L.) (Amount used to calculate the guideline amount of child support.)	\$ _____	\$ _____

**CALCULATION OF THE GUIDELINE AMOUNT OF SUPPORT (If applicable)**

	Custodial Parent		Noncustodial Parent	Combined
	_____ (name)		_____ (name)	
A. Adjusted Net Monthly Income	\$ _____	+	\$ _____	= \$ _____
B. Proportional Share of Income (Also used for Uncovered Medical Expenses)	_____ %	+	_____ %	= 100%
C. Number of Children for Whom Support is Sought				_____
D. Basic Support Obligation Using Only NCP's Adjusted Net Monthly Income (If low-income adjustment does not apply, enter N/A)			\$ _____	
E. Basic Support Obligation Using Combined Adjusted Net Monthly Income (If low-income adjustment applies enter N/A; see rule 9.3(2) and grid in rule 9.14(2).)				\$ _____
F. Each Parent's Share of the Basic Support Obligation Using Combined Incomes (If low-income adjustment applies enter N/A.)	\$ _____		\$ _____	
G. NCP's Basic Support Obligation Before Health Insurance (NCP's amount from line F or low-income adjustment amount from line D.)			\$ _____	
H. Cost of Child(ren)'s Health Insurance Premium (Difference between family and single cost.)	\$ _____		\$ _____	
I. Health Insurance Add-On or Deduction from NCP's Obligation		+/-	\$ _____	
J. Guideline Amount of Child Support for NCP (NCP's line G plus or minus NCP's line I.)			\$ _____	

**EXTRAORDINARY VISITATION CREDIT:**

(Complete only if noncustodial parent's court-ordered visitation exceeds 127 overnights per year)

K. NCP's Basic Support Obligation Before Health Insurance (Amount from NCP's line G.)	\$ _____
L. Number of court-ordered visitation overnights with the noncustodial parent	_____
M. Extraordinary Visitation Credit Percentage	_____ %
N. Extraordinary Visitation Credit (Line K multiplied by Line M.)	\$ _____
O. Guideline Amount of Child Support (After Credit for Extraordinary Visitation) (Line J minus line N; not less than \$30 for one child or \$50 for two or more children.)	\$ _____

**Parent Name (NCP)**

**V. RECOMMENDED AMOUNT OF CHILD SUPPORT:** \$ \_\_\_\_\_ per \_\_\_\_\_

**V-a. Recommended Amount of Accrued Support:** \$ \_\_\_\_\_ (see attachment)

**V-b. Recommended Amount of Cash Medical Support:** \$ \_\_\_\_\_ per \_\_\_\_\_

**V-c. Recommended Medical Support-Health Insurance:** \_\_\_\_\_ (see comments)

**Reasonable Cost for Health Insurance:** \$ \_\_\_\_\_ per month

**V-d. Uncovered Medical Expenses:** \_\_\_\_\_ %

**Parent Name (CP)**

**V-f. Recommended Amount of Cash Medical Support:** \$ \_\_\_\_\_ per \_\_\_\_\_

**V-g. Recommended Medical Support – Health Insurance:** \_\_\_\_\_ (see comments)

**Reasonable Cost for Health Insurance:** \$ \_\_\_\_\_ per month

**V-h. Uncovered Medical Expenses:** \_\_\_\_\_ %

**VI. Changes in Child Support Obligation as Number of Children Entitled to Support Changes**

For cases with multiple children based on present income and applicable guidelines calculation method.

**VI-a. Basic Obligation (if applicable)**

<u>Number of Children</u>	<u>NCP's Basic Support Obligation (NCP's Line G)**</u>	<u>Health Insurance Add-On or Deduction (NCP's Line I)**</u>	<u>Extraordinary Visitation Credit (If applicable.) (Line N)**</u>	<u>Guideline Amount of Child Support (Line J or O)**</u>
_____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____

\*\* (All Line references are to Division II., Calculation of the Guideline Amount of Support section of the worksheet.)

**VI-b. Joint (Equally Shared) Physical Care Obligation (if applicable)**

**VII. Qualified Additional Dependent Deduction (see guidelines for the definition of this term):**

Child's Name	Whose Child	Date of Birth	Paternity Establishment Method			
			Court/ Admin. Order	In Court Stmt. & Consent	Paternity Affidavit	Child Born During Marriage

Prepared by: \_\_\_\_\_  
Name

Prepared by: \_\_\_\_\_  
Name

## GUIDELINES CALCULATION COMMENTS

**Section -**  
Text

## GUIDELINES CALCULATION SUPPORTING DOCUMENTATION

**CP NAME**  
METHOD USED TO DETERMINE GROSS INCOME:  
(Method)

**NCP NAME**  
METHOD USED TO DETERMINE GROSS INCOME:  
(Method)

FEDERAL INCOME TAX:  
Yearly Taxable Income: \$  
Federal Income Tax Year:  
Number of Allowances:  
Federal Filing Status:

FEDERAL INCOME TAX:  
Yearly Taxable Income: \$  
Federal Income Tax Year:  
Number of Allowances:  
Federal Filing Status:

IOWA STATE INCOME TAX:  
Yearly Taxable Income: \$  
Iowa State Income Tax Year:  
Credits:

IOWA STATE INCOME TAX:  
Yearly Taxable Income: \$  
Iowa State Income Tax Year:  
Credits:

FICA TAX:  
Yearly Taxable Income: \$  
FICA Tax Year:

FICA TAX:  
Yearly Taxable Income: \$  
FICA Tax Year:

**MEDICAL SUPPORT – REASONABLE COST CALCULATION**

	<b>CP NAME</b>	<b>NCP NAME</b>
1. Preliminary net monthly income (Section I, Line K)	\$ _____	\$ _____
2. Number of children for whom support is sought.		_____
3. Percent from the Medical Support table (0-5%) – see Iowa Court Rule 9.12 (percent comes from the preliminary net income and number of children for whom support is sought.)	_____	_____
4. Total Gross Monthly Income (Section I, line A)	\$ _____	\$ _____
5. Reasonable cost (multiply gross income on line 4 by medical percent on line 3)	\$ _____	\$ _____
6. Family amount health insurance (if available)	\$ _____	\$ _____
7. Single amount health insurance (if available)	\$ _____	\$ _____
8. Family less single premium amount. Compare line 8 to line 5. If line 8 is more than line 5, the cost is not reasonable according to the Iowa Court rules. If line 8 is equal to or less than line 5, the cost is reasonable according to the Iowa Court rules.	\$ _____	\$ _____

## ACCRUED SUPPORT CALCULATION

**Assistance by period:**

	<u>Begin Date</u>	<u>Through Date</u>	<u>Number of Children</u>	<u>Guidelines Amount of Child Support</u>	<u>Number of Months</u>	<u>Subtotal for Period</u>
#1.			\$	X	=	\$
#2.			\$	X	=	\$
#3.			\$	X	=	\$
TOTAL:						\$ _____

**Deviations:**

Text	\$
Text	\$
Text	\$
Sum of Deviations:	\$ _____

Recommended Amount of Accrued Support: \$ \_\_\_\_\_

CSC No: \_\_\_\_\_

Party Name: \_\_\_\_\_

Dependents: \_\_\_\_\_

**FOSTER CARE FINANCIAL STATEMENT**

FOSTER CARE RECOVERY UNIT  
IOWA DEPT OF HUMAN SERVICES

Docket No: \_\_\_\_\_

County: \_\_\_\_\_

Worker ID: \_\_\_\_\_

Phone: \_\_\_\_\_

DATE: \_\_\_\_\_

**COMPLETE THIS FORM USING BLACK INK AND RETURN IN 10 DAYS**

**Because this form becomes public record, do not list any personal information such as:**

- ▶ the name of employer(s), or
- ▶ addresses, or
- ▶ social security numbers, or
- ▶ telephone numbers

I am currently .....Employed full-time    Employed part-time    Self-employed    Unemployed

Job Title or Occupation \_\_\_\_\_

I am paid: .....weekly    bi-weekly (every other week)    twice a month    monthly

My paychecks are: .....the same each pay period    different each pay period

The amount of my last paycheck (before deductions) was:.....\$ , .

*(Attach your last three pay stubs. If self-employed attach your last three income tax returns and all schedules)*

I get income from other sources (not FIP or TANF benefits).....  YES     NO

*Attach proof of other income such as pay stubs, award letters, or tax returns*

**Check All That Apply:**

Another Job    \$ , .     weekly    bi-weekly    twice a month    monthly

Unemployment    \$ , .     weekly    bi-weekly    twice a month    monthly

Worker's Compensation    \$ , .     weekly    bi-weekly    twice a month    monthly

Pension/Retirement    \$ , .     weekly    bi-weekly    twice a month    monthly

Veteran's Benefits    \$ , .     monthly

Supplemental Security Income (SSI)    \$ , .     monthly

Social Security Disability (SSD) or Social Security Retirement (SSR)  
\$ , .     monthly and benefits are for: myself    my spouse    my children

Other (please specify) \_\_\_\_\_  
\$ , .     weekly    bi-weekly    twice a month    monthly

List the cost for health or dental plans that are available to you *even if you are not currently enrolled:*

*Attach verification that shows all of the plans available to you, and the costs for BOTH family and single coverage.* If a health benefit plan is ordered, the cost of the health insurance premium for the child(ren) is added to the support obligation and shared between you and the other parent. If you want to carry health insurance for the child(ren) through a stepparent you may provide that plan information.

Family Health Insurance ..... \$ , .      weekly     bi-weekly     twice a month     monthly

Single Health Insurance ..... \$ , .      weekly     bi-weekly     twice a month     monthly

Family Dental Insurance ..... \$ , .      weekly     bi-weekly     twice a month     monthly

Single Dental Insurance ..... \$ , .      weekly     bi-weekly     twice a month     monthly

I currently carry a .....  Single Health Plan     Family Health Plan

I currently carry a .....  Single Dental Plan     Family Dental Plan

Health insurance is not available.

List the amounts you pay and attach proof of the following deductions:

Union Dues .....\$ . weekly bi-weekly twice a month monthly.

You may only receive a mandatory pension deduction if ***you do not contribute to Social Security.***

Mandatory Pension .....\$ . weekly bi-weekly twice a month monthly

**Mandatory Occupational License Fees** \$ .  yearly  other: \_\_\_\_\_ (Enter a time period)

Who pays your fees?  I do.  My employer does.

If you pay the fees, do you deduct them on your tax return as a business expense?  YES  NO

You may receive credit for other court ordered child support, medical support, or alimony you are paying.

I pay child support for other children of mine:

..... to Iowa Collection Services Center  to the Clerk of Court  to another state

I pay medical support for other children of mine:

..... to Iowa Collection Services Center  to the Clerk of Court  to another state

I pay alimony:

..... to Iowa Collection Services Center  to the Clerk of Court  to another state

***If you make payments through the clerk of court or another state, attach a copy of the court order and proof of payments. CSRU has record of payments made to Iowa Collection Services Center.***

I am currently married ..... YES  NO

I receive subsidized adoption benefits and the child's name is \_\_\_\_\_ ..... YES  NO

I have other children with no court order for support..... YES  NO

***(Include other children for whom you receive payments. Do not include stepchildren.)***

Child's Name	Date of Birth	Living Location	Relationship to Child
_____	_____	Foster Care__ Home __ Other__	Natural __ Step __ Adopted __
_____	_____	Foster Care__ Home __ Other__	Natural __ Step __ Adopted __
_____	_____	Foster Care__ Home __ Other__	Natural __ Step __ Adopted __

***You must provide proof such as: 1) birth certificate and marriage certificate, or 2) paternity affidavit, or 3) Court or Administrative Order. CSRU has record of paternity affidavits approved by the State of Iowa.***

**FOR PAYEES (person owed support or for court-ordered joint physical care, either parent) ONLY:**

I have child care expenses while I am at work ..... YES  NO

***(Attach proof of payments such as a letter from your day care provider or a copy of the Child and Dependent Care Expenses tax form.)***

If yes, list the amount.....\$ ,. weekly bi-weekly twice a month monthly

**FOR PAYORS (person paying support) ONLY:**

The children in this case stay overnight at least 128 times per year with me..... YES  NO

***This must be court ordered and a copy of the order must be attached. If the court ordered equally shared physical care, Extraordinary Visitation Credit does not apply.***

**OTHER HOUSEHOLD INCOME**

My spouse/partner is currently..... Employed full-time   Employed part-time   Self-employed   Unemployed

Job Title/Occupation: \_\_\_\_\_

He/She is paid: ..... weekly   bi-weekly (every two weeks)   twice a month   monthly

The amount of each paycheck (before deductions) is:.....\$ ,.

**MY MONTHLY EXPENSES**

Monthly House Payment or Rent:.....\$ ,.

Monthly Utilities (Such as heat, gas, water, and electric): .....\$ ,.

Monthly Cost of Meals or Food:.....\$ ,.

Monthly Telephone/Cell Phone Costs: .....\$ ,.

Monthly Clothing Costs:.....\$ ,.

Monthly Cable T.V. Costs: .....\$ ,.

Monthly Car Expenses (Not the amount of your car loan payment): .....\$ ,.

Monthly Internet Service: .....\$ ,.

Other expenses paid monthly:.....\$ ,.

Please specify other expenses: \_\_\_\_\_

There are other people who help pay my monthly expenses .....  YES    NO  
*(Do not include the spouse/partner listed above)*

If yes, list the amount they pay each month.....\$ ,.

**MY MONTHLY DEBTS/INSTALLMENT PAYMENTS**

For example: department stores, loan companies, banks, or auto loans.  
 (If you need more space, please attach a separate sheet of paper)

Payable to/Item	Monthly Payment Amount	Balance Due
_____	\$ <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
_____	\$ <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
_____	\$ <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>

**MY ASSETS**

Balance in Savings Account: .....\$ ,.

Name of Bank: \_\_\_\_\_

Balance in Checking Account:.....\$ ,.

Name of Bank: \_\_\_\_\_

Real Estate Value:.....\$ ,.

Balance owed on real estate:.....\$ ,.

Stocks:.....\$ ,.

Bonds:.....\$ ,.

**Vehicles:**

Type: \_\_\_\_\_ Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_

Type: \_\_\_\_\_ Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_

**SIGNATURE**

**I certify under penalty of perjury (punishment for lying) and under the laws of the State of Iowa that the above financial information I have given is true and correct. I understand that you may use this information in an action to establish or modify support for my children. I agree to accept service of all documents related to this action by first class mail. I further agree to inform your office of any change of address.**

SIGN HERE: \_\_\_\_\_ DATE: \_\_\_\_\_

## Request for Additional Financial Information

Date: \_\_\_\_\_  
Case Number: \_\_\_\_\_  
Worker ID: \_\_\_\_\_

Foster Care Recovery Unit

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_

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

We need more financial information from you to set your child support. The amount of your child support is based on the Supreme Court guidelines.

After you fill out the form, send it to the office listed at the top of the page. Please return the form within 10 days of the date of this request.

We may provide a copy of this form to the other parent. When we file this information with the court, the information will become public record.

If you have questions about filling out this form, contact your local office (see address and phone number above).

**470-2870, Foster Care Financial Statement**

Purpose	Use form 470-2870, <i>Foster Care Financial Statement</i> , to request the parents' financial information, which the Unit uses to compute the child support obligations.
Source	Enter an "F" in the GENERATE NOTICES field on the ADMIN screen to generate this form for the first time, or an "R" to regenerate it.  Enter a "Y" in the NOI field on the REVIEW1 or ADMOD1 screen to generate this form for the first time, or an "R" to regenerate it.
Completion	Complete this form if there is not currently an order for support for this payor or if there is currently an order for support for this payor.  When generated from the ADMIN, ADMOD1 or REVIEW1 screen, ICAR automatically enters all of the data into this form. If manually generated, you must enter the data.
Distribution	Personally serve, by certified mail or through the sheriff or process server, one copy of this form with: <ul style="list-style-type: none"><li>◆ Form 470-2983, <i>Notice of Support Debt: Foster Care</i>, and accompanying documents upon the payor if no order for support exists for this payor.</li><li>◆ Form 470-2154, <i>Request to Complete Financial Statement</i>, upon the payor if an order for support for the child in foster care exists for this payor.</li><li>◆ Form 470-3253, <i>Notice of Intent to Review and Adjust a Child Support Obligation</i>, to each necessary party if an order is being reviewed.</li><li>◆ Form 470-3437, <i>Notice of Intent to Modify a Child Support Obligation</i>, to each necessary party if an order is being modified.</li></ul>

Data

ICAR enters all of the following information on the form. You must enter the information for manually generated forms:

- ◆ Payor's name
- ◆ Payee's name
- ◆ Third party's name (if applicable)
- ◆ Children's names
- ◆ Date generated (current date in MM/DD/CCYY format)
- ◆ ICAR number
- ◆ Worker ID
- ◆ Court order number
- ◆ County where action is being filed



CHILD SUPPORT GUIDELINES WORKSHEET  
COVER LETTER

Date: \_\_\_\_\_

Case Number: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_,  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_, \_\_\_\_\_

Dependents:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

We, the Child Support Recovery Unit (CSRU), previously sent you a notice that we are attempting to enter an order for support for the above-named children. We asked both parents to complete and return a financial statement, along with proof of the income and expenses. We also provided information on the ways that we may determine a parent's income in order to calculate a support amount.

Enclosed is a worksheet showing our calculation and what we recommend for support. Be sure to review the entire worksheet right away. For a summary of our recommendations, see Section V. RECOMMENDED AMOUNT OF CHILD SUPPORT and the GUIDELINES CALCULATION COMMENTS.

**We intend to ask the court to enter a support order based on the worksheet**, subject to the following:

1. We will consider any new or different financial information from either parent or any other source ***within 10 days from the date of this letter*** before taking action to file a support order. A new worksheet will be issued to both parents if there is a change in the support recommendations.
2. If we are recommending cash medical support, we determined that there is no health benefit plan available that is accessible or reasonable in cost based on Iowa Code 252E. Let us know ***within 10 days from the date of this letter*** if you wish to consent to provide a health benefit plan or if you have additional information on a plan. A new worksheet will be issued to both parents if there is a change in the support recommendations.

We can consider a health benefit plan provided by a stepparent. As with a parent's health benefit plan, a stepparent's plan must be accessible and reasonable in cost. If not, you must contact us to consent to provide a stepparent plan. In addition, a parent may object to a stepparent providing a health benefit plan. If a parent objects for this reason in writing, the court will decide the issue based on what is equitable to the parties and children.

3. We may extend the accrued support period to include any additional periods public assistance is paid out prior to the entry of the order.

4. A parent served with a Notice of Child Support Debt or petition to establish support may request a court hearing to determine the issue of support. Neither this letter, nor the enclosed worksheet, affects your right or time limits for exercising this right.
5. In an administrative paternity case, the alleged father, mother, or CSRU may request genetic testing and/or a court hearing. If the alleged father fails to appear for scheduled genetic testing and fails to reschedule the test, we will enter a default administrative order establishing paternity and support, including medical support. Neither this letter, nor the enclosed worksheet, affects your right or time limits for exercising your right to genetic testing or a court hearing.

If a court hearing is held, we will present evidence to the court concerning the finances of both parents. This includes, but is not limited to, any financial statement provided by the parents and any worksheet we completed to calculate the amount of support or to determine medical support.

If you have any questions about this letter or the enclosed worksheet, please contact us at the address and phone number below.

\_\_\_\_\_  
\_\_\_\_\_  
Child Support Recovery Unit

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

PHONE: \_\_\_\_\_

**470-2950, Child Support Guidelines Worksheet Cover Letter**

Purpose	Use form 470-2950, <i>Child Support Guidelines Worksheet Cover Letter</i> , in an establishment action to notify the payor/alleged father and the caretaker (or the other parent, if not the caretaker) that the Unit will consider any new or different financial information they submit within ten days of the date on this form.
Source	Enter a "Y" in the GENERATE GUIDELINES CV LTR field on the ADMIN or the ADPAT2 screen to generate the form for the first time, or an "R" to regenerate it.
Completion	<p>Complete this form after you gather the parent's financial information and after you calculate the child support obligation.</p> <p>If generated from the ADMIN or the ADPAT2 screen, ICAR automatically enters all of the data. If manually generated, you must enter all of the data.</p>
Distribution	Send one copy each to the payor/alleged father and the payee by first-class mail with form 470-2640, <i>Child Support Guidelines Worksheet</i> . For caretaker cases, send one copy to the caretaker and to the other parent. For an interstate case, send the payee's copy to the responding state.
Data	<p>ICAR enters all of the information on the form. You must enter the information for manually generated forms:</p> <ul style="list-style-type: none"><li>◆ Data generated (current date in MM/DD/CCYY format)</li><li>◆ ICAR number</li><li>◆ Payee's name and address or responding state's IV-D agency's name and address</li><li>◆ Payor's/alleged father's name and address</li><li>◆ Children's names</li><li>◆ Worker name, ID, address and telephone number</li></ul>

**470-3515, Verification of Social Security Information**

Purpose	Use form 470-3515, <i>Verification of Social Security Information</i> , to verify social security disability (SSD) benefits received by the payor/alleged father and dependents.
Source	Because this form is not generated from a process screen, generate this form from the FORMVIEW screen.
Completion	You must first check online sources for SSA information. Use this form only when a parent is indicating they receive SSD benefits, but you cannot verify the payor's/alleged father's SSD benefits through the Income and Eligibility Verification System (IEVS) or the State Data Exchange System (SDXD).
Distribution	Send this form to your region's Social Security Administration (SSA) office with a self-addressed stamped envelope.
Data	The worker enters all of the following information: <ul style="list-style-type: none"><li>◆ Date generated</li><li>◆ SSA office address</li><li>◆ ICAR case number</li><li>◆ Payor's/alleged father's name, SSN, and date of birth</li><li>◆ Children's names, SSNs, and dates of birth</li><li>◆ Worker name and address</li></ul>

Iowa Department of Human Services  
 Verification of Social Security Information

Social Security Administration  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date: \_\_\_\_\_  
 Case Number: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 SSN: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

Dear Sir/Madam:

The Child Support Recovery Unit (CSRU) is a Department of Human Services agency charged with the duty of establishing and collecting child support payments in the State of Iowa. This request for information is for an emergency or sensitive situation. I checked the Federal Parent Locator Service (FPLS) SSA sources before sending this request. To enable our office to pursue a child support case concerning the above-named individual, we ask for your cooperation in obtaining the following information:

1. Is \_\_\_\_\_ receiving Social Security Benefits? Yes  No
2. If yes, how much is \_\_\_\_\_ receiving \$ \_\_\_\_\_ per month? (gross)
3. When did the payment of benefits begin? Month \_\_\_ Day \_\_\_ Year \_\_\_
4. What type of benefits are being paid? Disability  Retirement  SSI
5. What is \_\_\_\_\_ current or last known address? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
6. Are any dependents receiving benefits? Yes  No
7. Who is receiving the payments for the child? \_\_\_\_\_
8. If the dependents are not receiving benefits, are they entitled to benefits? Yes  No

Please indicate below which children are receiving benefits and the amounts. **Please add any additional children, if necessary.**

Child's Name (First, Middle, Last)	Date of Birth	SSN	Entitlement Date	Gross Monthly Benefit Amt.
				\$
				\$
				\$
				\$

Thank you for your cooperation. If you have any questions, you may call the local office listed below:

\_\_\_\_\_  
**Child Support Recovery Unit**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Phone: \_\_\_\_\_

**IRS-2441, Child and Dependent Care Expenses**

Purpose	Use form IRS-2441, <i>Child and Dependent Care Expenses</i> , to verify employment-related child care expenses when calculating a support obligation.
Source	Because the payee obtains this form from the Internal Revenue Service (IRS), this form does not generate from ICAR.
	For this form go to the IRS website: <a href="https://www.irs.gov/">https://www.irs.gov/</a>
Completion	The payee completes this form to receive credit from the IRS for employment-related child care expenses. The Unit reviews this completed form when giving the payee a child care deduction to gross income.

**IRS Schedule C, Profit or Loss From Business**

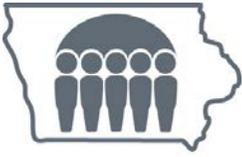
Purpose	Use form IRS Schedule C, <i>Profit or Loss From Business</i> , to verify income and expenses from self-employment when calculating a support obligation.
Source	Because the payor/alleged father or the payee obtains this form from the IRS, this form does not generate from ICAR.
	For this form go to the IRS website: <a href="https://www.irs.gov/">https://www.irs.gov/</a>
Completion	The payor/alleged father or the payee completes this form to report income or loss from self-employment to the IRS. The Unit reviews this completed form when determining income.

**IRS Schedule F, Profit or Loss From Farming**

Purpose	Use form IRS Schedule F, <i>Profit or Loss From Farming</i> , to verify income and loss from farming when calculating a support obligation.
	For this form go to the IRS website: <a href="https://www.irs.gov/">https://www.irs.gov/</a>
Source	Because the payor/alleged father or the payee obtains this form from the IRS, this form does not generate from ICAR.
Completion	The payor/alleged father or the payee completes this form to report income or loss from farming to the IRS. The Unit reviews this completed form when determining income.

**Schedule SE, Self-Employment Tax**

Purpose	Use Schedule SE, <i>Self-Employment Tax</i> , to verify the tax due on net earnings for self-employed individuals when calculating a support obligation.
Source	Because the payor/alleged father or the payee obtains this form from the IRS, this form does not generate from ICAR.
	For this form go to the IRS website: <a href="https://www.irs.gov/">https://www.irs.gov/</a>
Completion	The payor/alleged father or the payee completes this form to calculate the tax due on net earnings from self-employment and reports that amount to the IRS. The Unit reviews this completed form when determining income.



## Determining Medical Support Orders in the Establishment and Modification Processes

<b>Step 1: Does the payor have health insurance that is accessible to the child and reasonable in cost?</b>	<ul style="list-style-type: none"><li>• <b>Yes:</b> Order the payor to provide health insurance.</li><li>• <b>No:</b> Go to Step 2.</li></ul>
<b>Step 2: Is this a caretaker case?</b>	<ul style="list-style-type: none"><li>• <b>No:</b> Go to Step 3.</li><li>• <b>Yes, and this order will include obligations for both payors:</b> Go to Step 3 and consider the other parent's health insurance.</li><li>• <b>Yes, and there are separate orders for the two payors:</b> Go to Step 4. Do not consider the other parent's health insurance.</li></ul>
<b>Step 3: Does the payee/other parent have health insurance that is accessible to the child and reasonable in cost?</b>	<ul style="list-style-type: none"><li>• <b>Yes:</b> Order the payee/other parent to provide health insurance.</li><li>• <b>No:</b> Go to Step 4.</li></ul>
<b>Step 4: Has a parent requested to consent to health insurance that does not meet accessibility requirements?</b>	<ul style="list-style-type: none"><li>• <b>Yes:</b> Both parents must consent to accessibility for the same plan for CSRU to order it. If only one parent wants to consent, they will need to request a court hearing. Make sure either the cost for this plan is reasonable or the providing parent is consenting to cost also.</li><li>• <b>No:</b> Go to Step 5.</li></ul>
<b>Step 5: Has a parent requested to consent to carry health insurance above reasonable cost?</b>	<ul style="list-style-type: none"><li>• <b>Yes, both parents have:</b> If both parents want to provide the health insurance, a court hearing is needed to decide who will be ordered.</li><li>• <b>Yes, one parent has:</b> If a parent consents to provide health insurance above reasonable cost, order that parent as long as the plan is accessible. If it is not accessible, both parents need to consent to the lack of accessibility.</li><li>• <b>No:</b> Go to Step 6.</li></ul>
<b>Step 6: Is the payor's preliminary net monthly income \$0 to \$1,150?</b>	<ul style="list-style-type: none"><li>• <b>Yes:</b> Order the payor to provide health insurance when it is available at no cost to add the child.</li><li>• <b>No:</b> Go to Step 7.</li></ul>
<b>Step 7: Is the payor's only income NOT subject to income withholding?</b>	<ul style="list-style-type: none"><li>• <b>Yes:</b> Order the payor to provide health insurance when it becomes available at reasonable cost.</li><li>• <b>No:</b> Go to Step 8.</li></ul>
<b>Step 8: Is the payor or a child in the payor's home receiving FIP, Medicaid or <i>hawk-i</i>?</b>	<ul style="list-style-type: none"><li>• <b>Yes:</b> Order the payor to provide health insurance when it is available at no cost to add the child.</li><li>• <b>No:</b> Order the payor to provide cash medical support. Make sure the cash medical support is reasonable in cost.</li></ul>

**[RC-0133, Determining Medical Support Orders in the Establishment and Modification Processes Desk Aid](#)**

Purpose

This desk aid is provided to help you determine what type of medical support to seek in an establishment or modification action. This desk aid is based on:

- ◆ Code of Federal Regulations 303.31,
- ◆ Iowa Code section 252E.1A, and
- ◆ Iowa Court Rules, Chapter 9.