

Petitioner/Joint Petitioner A

Amended

**Interim Financial Summary
to Child Support Agency**

Respondent/Joint Petitioner B

Case No. _____

IV-D Case No.(s): _____

Hearing Date: _____ Court Official: [Name] _____

Petitioner/Joint Petitioner A's Name: _____ Birth Date: _____

Address: _____
Street City State Zip

Respondent/Joint Petitioner B's Name: _____ Birth Date: _____

Address: _____
Street City State Zip

Child(ren): (Provide Name and Birth Date)

Child's Name Birth date Child's Name Birth Date

Person who will RECEIVE payments: (Check one) Petitioner/
Joint Petitioner A Respondent/
Joint Petitioner B Other: _____

Payments received by WI to be sent to other state: (Specify) _____

Person who will MAKE payments: (Check one) Petitioner/Joint Petitioner A Respondent/Joint Petitioner B

Payor's employer: Name: _____ Phone: _____

Address: _____
Street City State Zip Fax: _____

By income assignment

Payor to send payments to: WI SCTF, Box 74200, Milwaukee, WI 53274-0200

1. Child Support \$ _____ per _____ effective _____ Per continuing order

2. Maintenance \$ _____ per _____ effective _____ Per continuing order
terminates _____

3. Health insurance premium \$ _____ per _____ effective _____ Per continuing order

4. Repay birth exp. of \$ _____ @ \$ _____ per _____ effective _____ Per continuing order

5. Repay _____ costs of \$ _____ @ \$ _____ per _____ effective _____ Per continuing order

6. Other: _____ of \$ _____ @ \$ _____ per _____ effective _____ Per continuing order

7. Total arrearages owed:

Child Support \$ _____ as of: _____; Payable \$ _____ per _____ effective _____

Maintenance/Sec. 71 \$ _____ as of: _____; Payable \$ _____ per _____ effective _____

Other \$ _____ as of: _____; Payable \$ _____ per _____ effective _____

8. Health ins: [Check one] BOTH PARENTS Petitioner/Joint Petitioner A Respondent/Joint Petitioner B

to provide if/when available at reasonable cost NO ORDER NOT AVAILABLE

Employer providing insurance if different than above: [Name, Address, Phone and Fax] _____

9. Uninsured medical expense: [Specify] Parents split evenly Other: _____

10. Tax exemption: CP NCP NCP if current Even years Odd years Other: _____

11. Other: [Specify] _____

Form prepared by: [Name] _____ Date: _____ Daytime Phone: _____

DISTRIBUTION:

- 1. Court
- 2. Child Support Agency