STATE OF WISCONSIN, CIRCUIT COURT, _____ COUNTY

Petitioner/Joint Petitioner A

_____

Respondent/Joint Petitioner B

_____

☐ Amended

Interim Financial Summary to Child Support Agency

Case No. _____

IV-D Case No.(s): _____

Hearing Date: _____

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: _____ Fax: _____
Street City State Zip

☐ By income assignment

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

☐ 1. Child Support ☐ Family Support $_____ per _____ effective _____ ☐ Per continuing order

☐ 2. Maintenance ☐ Section 71 $_____ 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 _____
- ☐ Family 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: _____

Court Official: [Name] _____ Date: _____

DISTRIBUTION:
1. Court
2. Child Support Agency