

Petitioner: \_\_\_\_\_  Amended

Respondent: \_\_\_\_\_ **Interim Financial Summary to Child Support Agency**

Case No. \_\_\_\_\_

IV-D Case No.(s): \_\_\_\_\_

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

Mother's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Father'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)  Mother  Father  Other: \_\_\_\_\_

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

Person who will MAKE payments: (check one)  Mother  Father

Payor's employer: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City St Zip Fax: \_\_\_\_\_

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/Sect 71 \$\_\_\_\_\_ as of: \_\_\_\_\_; Payable \$\_\_\_\_\_ per \_\_\_\_\_ effective \_\_\_\_\_

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

8. Health ins:[Check one]  BOTH PARENTS  MOTHER  FATHER 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