<County Name> County CSEA
<CSEA Address 1>
<CSEA Address 2>
<CSEA City, State, ZIP>

Telephone Number: <CSEA Local phone #>
Toll Free Number: <CSEA 800 #>
Fax Number: <CSEA Fax #>

<1st copy to obligor's and 2nd copy to obligee's first and last names>
<obligor or obligee's address 1>
<obligor or obligee's address 2>
<obligor or obligee's City, State, ZIP>

Obligor: <obligor's first and last names>
Obligee: <obligee's first and last names>

Date: <print date>
Case Number: <Case #>
Order Number: <order #>

ADMINISTRATIVE ADJUSTMENT REVIEW NOTIFICATION

In accordance with Ohio Revised Code (ORC) section 3119.60, the <County Name> County Child Support Enforcement Agency (CSEA) will conduct a review to determine if an adjustment (increase or decrease) to your current child or cash medical support obligation or your arrears payment is warranted. The CSEA may also review the support order with regards to medical support provisions to ensure the children under the order are covered by private health insurance and/or cash medical support.

Your review is scheduled for <scheduled date>. This is a desk review and it is not necessary for you to be present. A notice of results will be forwarded to you by mail with further instructions.

However, you must complete and return the attached Administrative Review and Adjustment Affidavit and Private Health Insurance Questionnaire and provide all mandatory verifications as soon as possible but no later than <scheduled date>. During the review, the CSEA will consider all information and verifications provided by both parties as well as any other relevant information and records available to the CSEA. If you fail to provide any required information or documents, it could result in unnecessary delays, your child and cash medical support obligations being calculated based on reasonable assumptions made regarding your income, a subpoena being issued to your employer to produce evidence regarding your income and health care benefits, your request for an administrative adjustment review being dismissed, or possible legal action to obtain the required information. Pursuant to ORC section 3119.72, failure to comply with this request for information may be enforced by requesting the court find you in contempt.

When the review is completed, a Recommendation regarding the child and cash medical support orders and health care provisions will be mailed to you, and will explain what steps you can take if you disagree with the Recommendations.

The CSEA and the agency attorney(s) represent the interests of the State of Ohio; not the obligor or obligee. The CSEA does not have the authority to address tax exemption, custody, visitation, or deviate from the Ohio Child Support Guidelines. Should you have any questions, please call us at <CSEA Local phone #> **or at** <CSEA 800 #>**. You can fax us at** <CSEA Fax #>**.**

WAIVER

☐ I would like the administrative review to be conducted on ____________ which is sooner than the date indicated above. I am submitting this Waiver, the Affidavit and Questionnaire, and all mandatory verifications within ten (10) days of the date indicated above. If I and the other party return the Waiver, the CSEA will conduct the administrative review on the date specified and agreed upon by both parties and the CSEA. If the parties fail to agree upon a date, the administrative review shall occur on <scheduled date>.

Signature: ____ Date: ______________________

Your Address: ____

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<obligor or obligee's address 1>
<obligor or obligee's address 2>
<obligor or obligee's City, State, ZIP>

ADMINISTRATIVE REVIEW AND ADJUSTMENT AFFIDAVIT

Obligor: <obligor's first and last names>
Obligee: <obligee's first and last names>

Date: <print date>
Case Number: <Case #>
Order Number: <order #>

My full name is: ____

My full address is: ____

____

My daytime phone number is: (___)_______________ My message phone number, if different, is: (___)________

My Social Security Number is: ____________________ My date of birth is: __________________

Are you the person who requested the Administrative Review? ☐ Yes ☐ No

LIST THE MINOR CHILD(REN) OF THIS ORDER FOR WHOM YOU HAVE LEGAL CUSTODY

Name	Date of Birth	Social Security Number	Does this child live with you?

☐I have _____ (number of) biological or adopted child(ren) from a different parent who lives with me (do not include step-children or the children listed above). If you checked this section, you must attach a copy of the birth or adoption certificate for each child and proof that each child is residing with you.

Case Number: <Case #>

INFORMATION REGARDING MY EMPLOYMENT AND OTHER INCOME
Please check (√) every box that applies to you.

1. ☐ I am currently employed by (name of employer): ____________________
Address of employer: ____________________
Payroll address of employer, if different: ____________________
Phone number of employer: (___) __________ Type of business: ____________________

I am ☐ an employee ☐ in the military service
☐ a subcontractor ☐ free lance ☐ subcontract out of a union hall

I work here ☐ full time ☐ part time ☐ seasonally (explain: ____________________)
I work ____ hours per week on average
I began working here on __________
I am paid ☐ weekly ☐ every two weeks ☐ twice a month
☐ once a month ☐ other (explain: ____________________)

I ☐ am an hourly employee ☐ am a salaried employee ☐ receive a base pay
☐ receive a weekly draw ☐ am paid per job ☐ receive tips
☐ receive a commission ☐ am in the military
I am paid $__________ per __________ (include shift premiums, if applicable, but do not include overtime pay or bonuses or commissions).
I also receive $________ per __________ (explain ____________________)
☐ I already or will receive overtime pay, bonuses, and/or commissions from this employer. This year, I have received $________ in overtime/bonus/commissions. Last year, I received $__________. Two years ago, I received $__________. Three years ago, I received $_________.
If you checked this section, you must attach an itemized statement from your employer that details overtime, bonus, and commission income for the last three years not including the current year. If you do not expect to continue to receive a similar amount of overtime/bonus/commission income, you must attach a letter from your employer indicating the amount of overtime/bonus/commission income you can reasonably anticipate to earn.

2. ☐ I have a second job with (name of employer) ____________________
Address of employer: ____________________
Payroll address of employer, if different: ____________________
Phone number of employer: (___)__________ Type of business: ____________________

I am ☐ an employee ☐ in the military service
☐ a subcontractor ☐ free lance ☐ subcontract out of a union hall
I work here ☐ full time ☐ part time ☐ seasonally (explain: ____________________)

I work ________hours per week on average I began working here on __________
I am paid $_______ ☐ weekly ☐ every two weeks ☐ twice a month
☐ once a month ☐ other (explain: ____________________)
I ☐ am an hourly employee ☐ am a salaried employee ☐ receive a base pay
☐ receive a weekly draw ☐ receive tips ☐ receive a commission
☐ am paid per job ☐ am in the military
I am paid $__________per __________(include shift premiums, if applicable, but do not include overtime pay or bonuses or commissions)
I also receive $________ per __________ (explain ____________________)

☐ I already (or will) receive overtime pay, bonuses, and/or commissions from this employer. This year, I have received $________ in overtime/bonus/commissions. Last year, I received $__________. Two years ago, I received $________. Three years ago, I received $_________.

If you checked this section, you must attach an itemized statement from your employer that details overtime, bonus, and commission income for the last three years not including the current year. If you do not expect to continue to receive a similar amount of overtime/bonus/commission income, attach a letter from your employer indicating the amount of overtime/bonus/commission income you can reasonably anticipate to earn.

3. ☐ I am self-employed as a ________________________________.
My total gross receipts during last year were $____________________
My total amount of ordinary and necessary business expenses last year was $______________ (ordinary and necessary business expenses in generating gross receipts means actual cash items expended and includes depreciation expenses of business equipment as shown on the books of a business entity. It does not include depreciation expenses and other non-cash items that are allowed as deductions on any federal tax return).
To calculate FICA, I'd like the CSEA to use:
☐ 5.6% of my gross income; or ☐ the marginal difference between the actual rate paid and the FICA rate.

4. ☐ I receive in-kind payments (e.g., free use of company car, free housing, reimbursed meals, and other benefits if the reimbursements are significant and reduce personal living expenses). Please list all in-kind payments and explain:
____
____

5. ☐ I receive income from one of the following sources:

I receive $	_______________	per	___________________	from dividend income or interest
I receive $	_______________	per	___________________	from pensions or retirement accounts
I receive $	_______________	per	___________________	from rental property
I receive $	_______________	per	___________________	from unemployment compensation
I receive $	_______________	per	___________________	from spousal support from a person who is not a party to this case
I receive $	_______________	per	___________________	from Social Security retirement benefits
I receive $	_______________	per	___________________	from Social Security disability benefits
I receive $	_______________	per	___________________	from Supplemental Security Income (SSI)
I receive $	_______________	per	___________________	from Workers' Compensation
I receive $	_______________	per	___________________	from disability benefits other than Social Security or Workers' Compensation
I receive $	_______________	per	___________________	from ___________________________(specify source)

If you checked this section, you must attach verification of the income you receive from each source.

6. ☐ I am not employed at this time and I do **not** receive unemployment compensation.
If you are unemployed and do not receive unemployment compensation benefits, please explain how you support yourself: ____
____
I am not employed now because: ____
____
I last worked on ________(enter date you last worked). I earned $_______________ annually at my last job.
Last Employer Name: ____
Last Employer Address: ____
Last Employer Phone Number: ____
My usual occupation is: ____
The last grade I completed in school was: ______________
If you are disabled and not receiving Workers' Compensation, Social Security Disability, or Supplement Security Income, you must attach a letter from a licensed health care provider that estimates how long you will be unable to work.

7. ☐ I receive income from the military (Example: military basic allowance for quarters, military basic subsistence pay, military cost of living adjustment, military special pay
I receive $ __________ per ______________ from ________________________________ (source)
I receive $ __________ per ______________ from ________________________________ (source)
I receive $ __________ per ______________ from ________________________________ (source)
I receive $ __________ per ______________ from ________________________________ (source)
If you checked this section, you must attach an itemized statement of the income you received during the last twelve months from the benefit provider.

8. I have worked for ______ (enter number) different employers over the last three years.

OTHER CONSIDERATIONS

9. ☐ I receive child support for the biological or adopted child(ren) who lives with me in the amount of $_________ per _________ through the ______________ (county) _____________ (state) child support agency in case number __________________.
☐ I receive child support for another biological or adopted child(ren) who lives with me in the amount of $_________ per ___________ through the ____________ (county) __________ (state) child support agency in case number: _________________.
If you checked either of these sections, you must attach a copy of every non-Ohio child support order plus proof of payment from the child support agency.

10. ☐ I am ordered to pay child support for my other child(ren) that is not part of this support order in the amount of $_________ per year to the ______________ (county) _____________ (state) child support agency.
If you checked this section, you must attach a copy of every non-Ohio child support order plus proof of payment from the child support agency.

11. ☐ I pay spousal support to __________________________ in the amount of $_________ per ___________ (week, month, etc.) through the ___________________ (county) ____________ (state) child support agency.
If you checked this section, you must attach a copy of every non-Ohio spousal support order plus proof of payment from the support agency.

12. ☐ I paid local (city) income tax last year (do not include property tax, state or federal tax, or school taxes) in the amount of $_________.
If you checked this section, you must attach a copy of last year's completed tax form.
☐ I expect to pay $_________ for local (city) income tax this year.

13. ☐ I have the following mandatory work-related deductions (e.g., Union dues, uniform rentals) from my pay:
$__________ per _____________ for ____
$__________ per _____________ for ____
If you checked this section, you must attach a letter from your union specifying the amount and frequency of your local union dues or a pay check stub that indicates the amount and frequency.

14. ☐ I paid $____________ per ____________ for child care expenses for my child(ren) by the parent named above (do not include any payment received from a child care program. Only include child care costs you had to pay for employment, employment training, or education related purposes. *Do not include child care costs you paid for other children.*) **If you checked this section, you must attach proof of payments in the form of receipts, cancelled checks, or notarized statement from the child care provider for the last twelve months.**

15. ☐ One or more of my children by the parent named above receives $_________ per _________ from a death, disability, or retirement benefit (such as Social Security Disability) through ☐ me or ☐ the other parent named above.
Explain: ____
If you checked this section, you must attach proof (i.e. an award letter) of the frequency and amount of each payment.

PRIVATE HEALTH INSURANCE QUESTIONNAIRE
(Medicaid and Medicare are not considered private health insurance)

16. ☐ I provide private health insurance for the following child(ren):
____

If you checked this section, you must attach proof of who is covered by your insurance policy.

17. ☐ I pay $___________ per year for private health insurance benefits that cover this child(ren). (do not include the amount that your employer pays for health insurance)
If you checked this section, you must attach proof of the amount you pay, unless the payment and the employee cost of individual (not family) health insurance coverage is noted on your paycheck stubs.

INSURANCE PLAN 1

Insurance Company Name: ____________________
Address: ____________________
Phone Number: (_____)__________________ Beginning Date of Coverage for child(ren): ________
Name of Policyholder: ________________________ ☐ The policyholder is my spouse
Policyholder Number: ______________________ Insurance Effective date: _________________
This is ☐ an individual plan or ☐ a group plan Group Number: ______________
The cost of single coverage is $___________ per month. The cost of family coverage is $____________ per month.
The cost of single plus one coverage is $ ___________________________ per month.
This insurance covers the following:

☐ Ambulance	☐ Dental	☐ Clinic	☐ Home Health Care
☐ Medical Supplies	☐ Lab/X-Ray	☐ Prescriptions	☐ Vision Care
☐ Extended Care	☐ Physician	☐ Inpatient Hospital	☐ Orthodontics
☐ Nursing Home	☐ Outpatient Hospital	☐ Hospital/Surgery	☐ Psychological/Psychiatric

☐ I must pay an annual deductible of $____________

INSURANCE PLAN 2

Insurance Company Name: ____________________
Address: ____________________
Phone Number: (_____)__________________ Beginning Date of Coverage for child(ren): ________
Name of Policyholder: ________________________ ☐ The policyholder is my spouse
Policyholder Number: ______________________ Insurance Effective date: _________________
This is ☐ an individual plan or ☐ a group plan Group Number: ______________
The cost of single coverage is $___________ per month. The cost of family coverage is $____________ per month.
The cost of single plus one coverage is $ ___________________________ per month.
This insurance covers the following:

☐ Ambulance	☐ Dental	☐ Clinic	☐ Home Health Care
☐ Medical Supplies	☐ Lab/X-Ray	☐ Prescriptions	☐ Vision Care
☐ Extended Care	☐ Physician	☐ Inpatient Hospital	☐ Orthodontics
☐ Nursing Home	☐ Outpatient Hospital	☐ Hospital/Surgery	☐ Psychological/Psychiatric

☐ I must pay an annual deductible of $____________

INSURANCE PLAN 3

Insurance Company Name: ____________________
Address: ____________________
Phone Number: (_____)__________________ Beginning Date of Coverage for child(ren): ________
Name of Policyholder: ________________________ ☐ The policyholder is my spouse
Policyholder Number: ______________________ Insurance Effective date: _________________

This is ☐ an individual plan or ☐ a group plan Group Number: ______________
The cost of single coverage is $___________ per month. The cost of family coverage is $____________ per month.
The cost of single plus one coverage is $ ___________________________ per month.
This insurance covers the following:

☐	Ambulance	☐	Dental	☐	Clinic	☐	Home Health Care
☐	Medical Supplies	☐	Lab/X-Ray	☐	Prescriptions	☐	Vision Care
☐	Extended Care	☐	Physician	☐	Inpatient Hospital	☐	Orthodontics
☐	Nursing Home	☐	Outpatient Hospital	☐	Hospital/Surgery	☐	Psychological/Psychiatric

☐ I must pay an annual deductible of $____________

18. ☐ I do not or cannot have the child(ren) covered by health insurance.
   - ☐ Health insurance is not available through my employer. (please provide a letter from your employer to this effect)
   - ☐ Health insurance is available through my employer but I do not have the child(ren) covered. (please provide a letter from your employer that details the cost of individual health insurance and the cost of family health insurance)
   - ☐ I am not yet eligible for health insurance. I will be eligible on ________________.

To the best of your knowledge, if both you and the other parent were ordered to provide private health insurance coverage for the child(ren) of this order, would this dual coverage provide for coordinated coverage of the child's medical benefits without unnecessary duplication of coverage? ☐ Yes ☐ No

VERIFICATIONS IN ADDITION TO THOSE NOTED ABOVE THAT MUST BE ATTACHED TO THIS AFFIDAVIT

☐ **I HAVE ATTACHED MY W-2, IRS 1040, IRS 1099, AND ALL OTHER IRS FORMS AND SCHEDULES FOR THE LAST THREE YEARS.**

☐ **I HAVE ATTACHED PROOF OF ALL NON-EMPLOYMENT INCOME I RECEIVE.**

☐ **I HAVE ATTACHED COPIES OF MY PAYCHECK STUBS FOR THE LAST SIX PAY PERIODS. IF I DID NOT HAVE MY PAYCHECK STUBS, I ATTACHED A LETTER FROM MY EMPLOYER INDICATING MY GROSS EARNINGS, HOW MUCH WAS FOR REGULAR HOURS, HOW MUCH WAS FOR OVERTIME HOURS OR BONUSES, AND HOW MUCH WAS DEDUCTED FROM MY EARNINGS AND WHY. IF I AM IN THE MILITARY, I PROVIDED AN ITEMIZED PAYROLL PRINTOUT.**

☐ **IF I HAVE RECEIVED OVERTIME OR BONUSES IN THE PAST AND I DO NOT EXPECT TO CONTINUE TO RECEIVE OVERTIME OR BONUSES, I HAVE ATTACHED A LETTER FROM MY EMPLOYER EXPLAINING WHY I WILL NOT BE ALLOWED TO WORK ANY MORE OVERTIME OR RECEIVE ANY MORE BONUSES.**

If you fail to provide any required information or documents, it could result in unnecessary delays, your child support and cash medical support order being calculated based on reasonable assumptions made regarding your income, a subpoena being issued to your employer to produce evidence regarding your income and medical benefits, your request for an administrative adjustment review being dismissed, or possible legal action in court to obtain the required information. Pursuant to ORC section 3119.72, failure to comply with this request for information may be enforced by requesting the court find you in contempt.

AFFIDAVIT SIGNATURE

I hereby swear or affirm that the information contained herein or attached hereto is true, correct, and complete to the best of my knowledge, information, and belief.

____ _______________________________

Signature Date

(_______)____________________________________

Your Telephone Number