

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, state Bar number, and address) or
GOVERNMENTAL AGENCY (under Family Code, §§ 17400, 17406):

FOR COURT USE ONLY

TELEPHONE NO.:

FAX NO. (Optional):

E-MAIL ADDRESS (Optional):

ATTORNEY FOR (Name):

SUPERIOR COURT OF CALIFORNIA, COUNTY OF

STREET ADDRESS:

MAILING ADDRESS:

CITY AND ZIP CODE:

BRANCH NAME:

PETITIONER/PLAINTIFF:

RESPONDENT/DEFENDANT:

OTHER PARENT:

DECLARATION OF PAYMENT HISTORY

CASE NUMBER:

1. Declaration of (name):
2. Based on my records or my recollection, I declare that the information on the attached pages showing the amounts ordered and the amounts paid are true and correct for the following obligations (*check all that apply*):

a. <input type="checkbox"/>	Child support	d. <input type="checkbox"/>	Medical support	g. <input type="checkbox"/>	Other (specify):
b. <input type="checkbox"/>	Spousal support	e. <input type="checkbox"/>	Unreimbursed medical expenses		
c. <input type="checkbox"/>	Family support	f. <input type="checkbox"/>	Unreimbursed child care expenses		

3. Number of pages attached: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:



(TYPE OR PRINT NAME)

(SIGNATURE OF DECLARANT)

SUPPORT ARREARAGE SUMMARY

This summary is for arrearage for the periods specified in the attached pages.

Interest is calculated through (*specify date*):

	<u>Principal:</u>	<u>Interest (optional):</u>	<u>Total Arrearage:</u>
CHILD SUPPORT:	\$_____	\$_____	\$_____
SPOUSAL SUPPORT:	\$_____	\$_____	\$_____
FAMILY SUPPORT:	\$_____	\$_____	\$_____
MEDICAL SUPPORT:	\$_____	\$_____	\$_____
UNREIMBURSED MEDICAL EXPENSES:	\$_____	\$_____	\$_____
UNREIMBURSED CHILD CARE EXPENSES:	\$_____	\$_____	\$_____
OTHER (specify):	\$_____	\$_____	\$_____

NOTICE: Interest that is not calculated is not waived

Date:

Submitted by:



(TYPE OR PRINT NAME)

(SIGNATURE)

Details of the arrearage statement, consisting of (*specify number*) pages, are attached.

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