

**Superior Court of California  
County of Riverside  
Request for Order Regarding Overdue Support  
Cover Sheet**

**Your Information**

Name (First, Middle, Last): \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone Number (home or cellular): \_\_\_\_\_

**Type Petitioner's Name Here (person who started case):** \_\_\_\_\_

**Type Respondent's Name Here:** \_\_\_\_\_

**Type of Support You Are Owed:**     Child Support     Spousal Support

**Case Number (fill in if you have one):** \_\_\_\_\_

**Where is the case filed? (Select location as it appears on Complaint):**

4175 Main Street, Riverside, CA 92501

880 N. State Street, Hemet, CA 92543

46-200 Oasis Street, Indio, CA 92201

265 N. Broadway, Blythe, CA 92225





PETITIONER: RESPONDENT: OTHER PARENT/PARTY:	CASE NUMBER:
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3.  CHILD SUPPORT

(Note: An earnings assignment may be issued. See *Income Withholding for Support* (form FL-195))

a. I request that the court order child support as follows:

Child's name and age	<input type="checkbox"/>	I request support for each child	Monthly amount (\$) requested
based on the child support guideline. (if not by guideline)			

b.  I want to change a current court order for child support filed on (date):  [Attachment 3a.](#)  
 The court ordered child support as follows (specify):

c. I have completed and filed with this *Request for Order* a current *Income and Expense Declaration* (form FL-150) or I filed a current *Financial Statement (Simplified)* (form FL-155) because I meet the requirements to file form FL-155.

d. The court should make or change the support orders because (specify):  [Attachment 3d.](#)

4.  SPOUSAL OR DOMESTIC PARTNER SUPPORT

(Note: An *Earnings Assignment Order For Spousal or Partner Support* (form FL-435) may be issued.)

- a.  Amount requested (monthly): \$
- b.  I want the court to  change  end the current support order filed on (date):  
 The court ordered \$ \_\_\_\_\_ per month for support.
- c.  This request is to modify (change) spousal or partner support after entry of a judgment.  
 I have completed and attached *Spousal or Partner Support Declaration Attachment* (form FL-157) or a declaration that addresses the same factors covered in form FL-157.
- d. I have completed and filed a current *Income and Expense Declaration* (form FL-150) in support of my request.
- e. The court should should make, change, or end the support orders because (specify):  [Attachment 4e.](#)

5.  PROPERTY CONTROL

I request temporary emergency orders

a. The  petitioner  respondent  other parent/party be given exclusive temporary use, possession, and control of the following property that we  own or are buying  lease or rent (specify):

b. The  petitioner  respondent  other parent/party be ordered to make the following payments on debts and liens coming due while the order is in effect:

Pay to: _____	For: _____	Amount: \$ _____	Due date: _____
Pay to: _____	For: _____	Amount: \$ _____	Due date: _____
Pay to: _____	For: _____	Amount: \$ _____	Due date: _____
Pay to: _____	For: _____	Amount: \$ _____	Due date: _____

c.  This is a change from the current order for property control filed on (date):

d. Specify in [Attachment 5d](#) the reasons why the court should make or change the property control orders.

PETITIONER: RESPONDENT: OTHER PARENT/PARTY:	CASE NUMBER:
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6.  **ATTORNEY'S FEES AND COSTS**  
 I request attorney's fees and costs, which total (specify amount): \$ \_\_\_\_\_ . I filed the following to support my request:
- a. A current *Income and Expense Declaration* ([form FL-150](#)).
  - b. A *Request for Attorney's Fees and Costs Attachment* ([form FL-319](#)) or a declaration that addresses the factors covered in that form.
  - c. A *Supporting Declaration for Attorney's Fees and Costs Attachment* ([form FL-158](#)) or a declaration that addresses the factors covered in that form.

7.  **DOMESTIC VIOLENCE ORDER**

- Do not use this form to ask for domestic violence restraining orders! Read [form DV-505-INFO](#), *How Do I Ask for a Temporary Restraining Order*, for forms and information you need to ask for domestic violence restraining orders.
- Read [form DV-400-INFO](#), *How to Change or End a Domestic Violence Restraining Order* for more information.

- a. The *Restraining Order After Hearing* (form DV-130) was filed on (date): \_\_\_\_\_
- b. I request that the court  change  end the personal conduct, stay-away, move-out orders, or other protective orders made in *Restraining Order After Hearing* (form DV-130). (If you want to change the orders, complete 7c.)
- c.  I request that the court make the following changes to the restraining orders (specify):  [Attachment 7c.](#)
- d. I want the court to change or end the orders because (specify):  [Attachment 7d.](#)

8.  **OTHER ORDERS REQUESTED (specify):**  [Attachment 8.](#)

9.  **TIME FOR SERVICE / TIME UNTIL HEARING** I urgently need:
- a.  To serve the *Request for Order* no less than (number): \_\_\_\_\_ court days before the hearing.
  - b.  The hearing date and service of the the *Request for Order* to be sooner.
  - c. I need the order because (specify):  [Attachment 9c.](#)

10.  **FACTS TO SUPPORT** the orders I request are listed below. The facts that I write in support and attach to this request cannot be longer than 10 pages, unless the court gives me permission.  [Attachment 10.](#)

I declare under penalty of perjury under the laws of the State of California that the information provided in this form and all attachments is true and correct.

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

\_\_\_\_\_  
 (TYPE OR PRINT NAME)

\_\_\_\_\_  
 (SIGNATURE OF APPLICANT)



**Requests for Accommodations**

Assistive listening systems, computer-assisted real-time captioning, or sign language interpreter services are available if you ask at least five days before the proceeding. Contact the clerk's office or go to [www.courts.ca.gov/forms](http://www.courts.ca.gov/forms) for *Request for Accommodations by Persons With Disabilities and Response* ([form MC-410](#)). (Civ. Code, § 54.8.)

PETITIONER/PLAINTIFF: RESPONDENT/DEFENDANT: OTHER PARENT/PARTY:	CASE NUMBER:
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**APPLICATION TO DETERMINE ARREARS**

Attachment to *Request for Order* (form [FL-300](#))

- Child Support**   
  **Spousal or partner support**   
  **Family support**   
  **Medical support**  
 **Unreimbursed expenses**   
  **Unreimbursed medical expenses**  
 **Other (specify):**

1. I ask that the amount of past due support payments (arrears) be decided in this case.
2. I have attached (*check all that apply*):
  - a.  a *Declaration of Payment History* ([FL-420](#)).
  - b.  a *Payment History Attachment* ([FL-421](#)).
  - c.  Other (*specify*):
3.  I ask that the amount of past due support payments (arrears) be decided in this case.
  - a.  I have already paid     some     all    of the support ordered. Proof of payment is attached.
  - b.  The children for whom support is to be paid were living with me full time for the period from \_\_\_\_\_ to: \_\_\_\_\_ . I provided all of their support during that period. I am attaching a detailed declaration explaining these facts and supporting documentation, including any proof that the children were living with me.
  - c.  Other (*specify*):
4.  I have previously asked the other parent for payment and provided the other parent with an itemized statement of the unreimbursed  childcare expense  medical expense. (*Attach copies of all bills being claimed and proof of any payments that you have made on these bills.*)
5.  I am asking the other person to pay  attorney fees  costs. *Income and Expense Declaration* (form [FL-150](#)) is attached.
6. Facts in support of the relief requested are (*specify*):

contained in the attached declaration.

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

Date:

\_\_\_\_\_

(TYPE OR PRINT NAME)

▶

\_\_\_\_\_

(SIGNATURE OF DECLARANT)

- |   |  |
|---|--|
| <input type="checkbox"/> Petitioner/plaintiff | <input type="checkbox"/> Respondent/defendant      |
| <input type="checkbox"/> Other parent/party   | <input type="checkbox"/> Other ( <i>specify</i> ): |

**NOTICE: This form must be attached to *Request for Order* (FL-300)**

**NOT A COURT ORDER**

Page \_\_\_\_\_ of \_\_\_\_\_

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, state Bar number, and address) or GOVERNMENTAL AGENCY (under Family Code, §§ 17400, 17406):   TELEPHONE NO.: _____ FAX NO. (Optional): _____ E-MAIL ADDRESS (Optional): _____ ATTORNEY FOR (Name): _____	<b>FOR COURT USE ONLY</b>
<b>SUPERIOR COURT OF CALIFORNIA, COUNTY OF F-19FG-89</b> _____ _____ _____ _____	
PETITIONER/PLAINTIFF:  RESPONDENT/DEFENDANT:  OTHER PARENT:	
<b>DECLARATION OF PAYMENT HISTORY</b>	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.

PETITIONER/PLAINTIFF:  RESPONDENT/DEFENDANT:  OTHER PARENT:	CASE NUMBER:
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**PAYMENT HISTORY FOR (check one):**

- Child   
  Spousal   
  Family   
  Medical   
  Unreimbursed child care  
 Unreimbursed medical   
  Other (specify):

	Year _____		Year _____		Year _____	
	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						
<b>TOTAL</b>						

	Year _____		Year _____		Year _____	
	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						
<b>TOTAL</b>						

**INSTRUCTIONS FOR COMPLETING PAYMENT RECORD**

**You must complete a separate *Payment History Attachment* form for each type of support paid.** Enter the year, list the amount ordered, and the amount paid for each month during that year. If the amounts repeat in a column, you can use an arrow as shown in the example below. Add the amounts in each column to get the yearly totals. Enter the totals at the bottom.

Attach additional sheets and supporting documents (bills, receipts, and other proof of expense) as necessary.

Child

Spousal

	Year <u>2000</u>		Year <u>2001</u>	
	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID
January	100	0	100	100
February		↓		0
March		↓		↓
April		100		100
May		100		0
June		100		↓
July		0		↓
August		↓		100
September		↓		100
October		100		0
November	↓	↓	↓	↓
December	↓	↓	↓	↓
<b>TOTAL</b>	<b>1,200</b>	<b>600</b>	<b>1,200</b>	<b>400</b>

	AMOUNT ORDERED	AMOUNT PAID
January	100	0
February		↓
March		↓
April		100
May		100
June		100
July		0
August		↓
September		↓
October		100
November	↓	↓
December	↓	↓
<b>TOTAL</b>	<b>1,200</b>	<b>600</b>

**UNREIMBURSED CHILD CARE, MEDICAL, OR OTHER EXPENSES:**

You must complete a separate *Payment History Attachment* form for each type of unreimbursed expense. If you have more than one bill, receipt, and other proof of expense per month use an additional declaration page (form MC-031) or separate page. **1.)** Itemize each expense; **2.)** attach proof of bill or payment; **3.)** mark each bill or payment with an Exhibit # \_\_\_\_\_; **4.)** group the bills, receipts, and other proof of expense in chronological order for each month; and **5.)** enter the total bills, receipts, and other proof of expense for each month. If your court order did not state a specific due date for reimbursement, then include that amount in the month that the expense was incurred.

Unreimbursed child care expenses

Unreimbursed medical expenses

	Year <u>2001</u>	
	AMOUNT ORDERED	AMOUNT PAID
January	50% (\$200)	0
February	50% (\$200)	100
March	50% (\$200)	0
April	50% (\$200)	50
May		
June		
July		
August		
September		
October		
November		
December		
<b>TOTAL</b>	<b>\$400</b>	<b>150</b>

	Year <u>2001</u>	
	AMOUNT ORDERED	AMOUNT PAID
January	50% (\$200)	0
February		
March	50% (\$200)	0
April	50% (\$75)	0
May		
June		
July		
August		
September		
October		
November		
December		
<b>TOTAL</b>	<b>\$237.50</b>	<b>0</b>

**Form MC-031**

Petitioner/Plaintiff	CASE NUMBER
Defendant/Respondent	
I request reimbursement for 50% of these expenses, which are supported by copies of bills, receipts, and other proof of expense.	
01/04/01 Dr. Adams	\$45.00 Exhibit A
01/08/01 Dr. Lee, D.D.S.	\$155.00 Exhibit B
02/15/01 AB X-ray Inc.	\$200.00 Exhibit C
04/26/01 Kids Therapy	\$75.00 Exhibit D
Child care expenses:	
01/02 ABC School 50% (\$200)	] Exhibit E
02/02 ABC School 50% (\$200)	
03/02 ABC School 50% (\$200)	
04/02 ABC School 50% (\$200)	
I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.	
..... (TYPE OR PRINT NAME)	..... (SIGNATURE OF DECLARANT)
Form MC-031	<b>ATTACHED DECLARATION</b>

PARTY WITHOUT ATTORNEY OR ATTORNEY     TELEPHONE NO.: E-MAIL ADDRESS: ATTORNEY FOR (name):	<b>FOR COURT USE ONLY</b>
<b>SUPERIOR COURT OF CALIFORNIA, COUNTY OF RIVERSIDE</b>	
PETITIONER: RESPONDENT: OTHER PARTY/PARENT/CLAIMANT:	
<b>INCOME AND EXPENSE DECLARATION</b>	CASE NUMBER:

**1. Employment** (Give information on your current job or, if you're unemployed, your most recent job.)

Attach copies of your pay stubs for last two months (black out Social Security numbers).

- a. Employer:
- b. Employer's address:
- c. Employer's phone number:
- d. Occupation:
- e. Date job started:
- f. If unemployed, date job ended:
- g. I work about \_\_\_\_\_ hours per week.
- h. I get paid \$ \_\_\_\_\_ gross (before taxes)  per month  per week  per hour.

**(If you have more than one job, attach an 8 1/2-by-11-inch sheet of paper and list the same information as above for your other jobs. Write "Question 1—Other Jobs" at the top.)**

**2. Age and education**

- a. My age is (specify): \_\_\_\_\_
- b. I have completed high school or the equivalent:  Yes  No If no, highest grade completed (specify): \_\_\_\_\_
- c. Number of years of college completed (specify): \_\_\_\_\_ Degree(s) obtained (specify): \_\_\_\_\_
- d. Number of years of graduate school completed (specify): \_\_\_\_\_ Degree(s) obtained (specify): \_\_\_\_\_
- e. I have:  professional/occupational license(s) (specify): \_\_\_\_\_  
 vocational training (specify): \_\_\_\_\_

**3. Tax information**

- a.  I last filed taxes for tax year (specify year): \_\_\_\_\_
- b. My tax filing status is  single  head of household  married, filing separately  
 married, filing jointly with (specify name): \_\_\_\_\_
- c. I file state tax returns in  California  other (specify state): \_\_\_\_\_
- d. I claim the following number of exemptions (including myself) on my taxes (specify): \_\_\_\_\_

- 4. **Other party's income.** I estimate the gross monthly income (before taxes) of the other party in this case at (specify): \$ \_\_\_\_\_  
 This estimate is based on (explain): \_\_\_\_\_

**(If you need more space to answer any questions on this form, attach an 8 1/2-by-11-inch sheet of paper and write the question number before your answer.)** Number of pages attached: \_\_\_\_\_

I declare under penalty of perjury under the laws of the State of California that the information contained on all pages of this form and any attachments is true and correct.

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

\_\_\_\_\_ \_\_\_\_\_  
 (TYPE OR PRINT NAME) (SIGNATURE OF DECLARANT)

PETITIONER: RESPONDENT: OTHER PARTY/PARENT/CLAIMANT:	CASE NUMBER:
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**Attach copies of your pay stubs for the last two months and proof of any other income. Take a copy of your latest federal tax return to the court hearing. (Black out your Social Security number on the pay stub and tax return.)**

**5. Income** (For average monthly, add up all the income you received in each category in the last 12 months and divide the total by 12.)

	Last month	Average monthly
a. Salary or wages (gross, before taxes).....	\$ _____	_____
b. Overtime (gross, before taxes).....	\$ _____	_____
c. Commissions or bonuses.....	\$ _____	_____
d. Public assistance (for example: TANF, SSI, GA/GR) <input type="checkbox"/> currently receiving .....	\$ _____	_____
e. Spousal support <input type="checkbox"/> from this marriage <input type="checkbox"/> from a different marriage <input type="checkbox"/> federally taxable* .....	\$ _____	_____
f. Partner support <input type="checkbox"/> from this domestic partnership <input type="checkbox"/> from a different domestic partnership .....	\$ _____	_____
g. Pension/retirement fund payments.....	\$ _____	_____
h. Social Security retirement (not SSI).....	\$ _____	_____
i. Disability: <input type="checkbox"/> Social Security (not SSI) <input type="checkbox"/> State disability (SDI) <input type="checkbox"/> Private insurance .....	\$ _____	_____
j. Unemployment compensation.....	\$ _____	_____
k. Workers' compensation.....	\$ _____	_____
l. Other (military allowances, royalty payments) (specify): .....	\$ _____	_____

**6. Investment income** (Attach a schedule showing gross receipts less cash expenses for each piece of property.)

a. Dividends/interest.....	\$ _____	
b. Rental property income.....	\$ _____	
c. Trust income.....	\$ _____	
d. Other (specify): .....	\$ _____	

**7. Income from self-employment, after business expenses for all businesses**..... \$ \_\_\_\_\_

I am the  owner/sole proprietor  business partner  other (specify): \_\_\_\_\_

Number of years in this business (specify): \_\_\_\_\_

Name of business (specify): \_\_\_\_\_

Type of business (specify): \_\_\_\_\_

**Attach a profit and loss statement for the last two years or a Schedule C from your last federal tax return. Black out your Social Security number. If you have more than one business, provide the information above for each of your businesses.**

8.  **Additional income.** I received one-time money (lottery winnings, inheritance, etc.) in the last 12 months (specify source and amount): \_\_\_\_\_

9.  **Change in income.** My financial situation has changed significantly over the last 12 months because (specify): \_\_\_\_\_

**10. Deductions**

	Last month
a. Required union dues.....	\$ _____
b. Required retirement payments (not Social Security, FICA, 401(k), or IRA).....	\$ _____
c. Medical, hospital, dental, and other health insurance premiums (total monthly amount).....	\$ _____
d. Child support that I pay for children from other relationships.....	\$ _____
e. Spousal support that I pay by court order from a different marriage <input type="checkbox"/> federally tax deductible*.....	\$ _____
f. Partner support that I pay by court order from a different domestic partnership.....	\$ _____
g. Necessary job-related expenses not reimbursed by my employer (attach explanation labeled "Question 10g").....	\$ _____

**11. Assets**

	Total
a. Cash and checking accounts, savings, credit union, money market, and other deposit accounts.....	\$ _____
b. Stocks, bonds, and other assets I could easily sell.....	\$ _____
c. All other property, <input type="checkbox"/> real and <input type="checkbox"/> personal (estimate fair market value minus the debts you owe).....	\$ _____

\* Check the box if the spousal support order or judgment was executed by the parties and the court before January 1, 2019, or if a court-ordered change maintains the spousal support payments as taxable income to the recipient and tax deductible to the payor.

PETITIONER: RESPONDENT: OTHER PARTY/PARENT/CLAIMANT:	CASE NUMBER:
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**12. The following people live with me:**

Name	Age	How the person is related to me (ex: son)	That person's gross monthly income	Pays some of the household expenses?
a.				<input type="checkbox"/> Yes <input type="checkbox"/> No
b.				<input type="checkbox"/> Yes <input type="checkbox"/> No
c.				<input type="checkbox"/> Yes <input type="checkbox"/> No
d.				<input type="checkbox"/> Yes <input type="checkbox"/> No
e.				<input type="checkbox"/> Yes <input type="checkbox"/> No

**13. Average monthly expenses**     Estimated expenses     Actual expenses     Proposed needs

a. Home: (1) <input type="checkbox"/> Rent or <input type="checkbox"/> mortgage..... \$ _____ If mortgage: (a) average principal:   \$ _____ (b) average interest:    \$ _____ (2) Real property taxes..... \$ _____ (3) Homeowner's or renter's insurance (if not included above)..... \$ _____ (4) Maintenance and repair..... \$ _____ b. Health-care costs not paid by insurance..... \$ _____ c. Child care..... \$ _____ d. Groceries and household supplies..... \$ _____ e. Eating out..... \$ _____ f. Utilities (gas, electric, water, trash)..... \$ _____ g. Telephone, cell phone, and e-mail..... \$ _____	h. Laundry and cleaning..... \$ _____ i. Clothes..... \$ _____ j. Education..... \$ _____ k. Entertainment, gifts, and vacation..... \$ _____ l. Auto expenses and transportation (insurance, gas, repairs, bus, etc.)..... \$ _____ m. Insurance (life, accident, etc.; do not include auto, home, or health insurance)..... \$ _____ n. Savings and investments..... \$ _____ o. Charitable contributions..... \$ _____ p. Monthly payments listed in item 14 (itemize below in 14 and insert total here).... \$ _____ q. Other (specify): \$ _____ <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">                     r. <b>TOTAL EXPENSES</b> (a-q) (do not add in the amounts in a(1)(a) and (b)) \$ _____                 </div> s. <b>Amount of expenses paid by others</b> \$ _____
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**14. Installment payments and debts not listed above**

Paid to	For	Amount	Balance	Date of last payment
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	

**15. Attorney fees** (This information is required if either party is requesting attorney fees):

- a. To date, I have paid my attorney this amount for fees and costs (specify): \$
- b. The source of this money was (specify):
- c. I still owe the following fees and costs to my attorney (specify total owed): \$
- d. My attorney's hourly rate is (specify):

I confirm this fee arrangement.

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

\_\_\_\_\_  
 (TYPE OR PRINT NAME)

\_\_\_\_\_  
 (SIGNATURE OF DECLARANT)

PETITIONER: RESPONDENT: OTHER PARTY/PARENT/CLAIMANT:	CASE NUMBER:
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**CHILD SUPPORT INFORMATION**  
**(NOTE: Fill out this page only if your case involves child support.)**

**16. Number of children**

- a. I have *(specify number)*: \_\_\_\_\_ children under the age of 18 with the other parent in this case.
- b. The children spend \_\_\_\_\_ percent of their time with me and \_\_\_\_\_ percent of their time with the other parent.  
*(If you're not sure about percentage or it has not been agreed on, please describe your parenting schedule here.)*

**17. Children's health-care expenses**

- a.  I do  I do not have health insurance available to me for the children through my job.
- b. Name of insurance company: \_\_\_\_\_
- c. Address of insurance company: \_\_\_\_\_
  
- d. The monthly cost for the **children's** health insurance is or would be *(specify)*: \$ \_\_\_\_\_  
*(Do not include the amount your employer pays.)*

**18. Additional expense for the children in this case**

- |  | Amount per month |
|--|------------------|
| a. Childcare so I can work or get job training.....                            | \$ _____         |
| b. Children's health care not covered by insurance.....                        | \$ _____         |
| c. Travel expenses for visitation.....   | \$ _____         |
| d. Children's educational or other special needs <i>(specify below)</i> :..... | \$ _____         |

**19. Special hardships.** I ask the court to consider the following special financial circumstances  
*(attach documentation of any item listed here, including court orders):*

- |  | Amount per month | For how many months? |
|--|------------------|----------------------|
| a. Extraordinary health expenses not included in 18b.....  | \$ _____         | _____                |
| b. Major losses not covered by insurance <i>(examples: fire, theft, other insured loss)</i> .....  | \$ _____         | _____                |
| c. (1) Expenses for my minor children who are from other relationships and are living with me..... | \$ _____         | _____                |
| (2) Names and ages of those children <i>(specify)</i> :  |                  |                      |
| (3) Child support I receive for those children.....  | \$ _____         |                      |

The expenses listed in a, b, and c create an extreme financial hardship because *(explain)*:

**20. Other information I want the court to know concerning support in my case *(specify)*:**

SHORT TITLE: <hr/>	CASE NUMBER:
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**ATTACHMENT** (Number): \_\_\_\_\_

*(This Attachment may be used with any Judicial Council form.)*

*(If the item that this Attachment concerns is made under penalty of perjury, all statements in this Attachment are made under penalty of perjury.)*

Page \_\_\_\_\_ of \_\_\_\_\_  
*(Add pages as required)*

ATTORNEY OR PARTY WITHOUT ATTORNEY OR GOVERNMENTAL AGENCY (under Family Code, §§ 17400,17406 <i>(Name, State Bar number, and address):</i>  <hr/>  TELEPHONE NO.: _____ FAX NO.: _____ ATTORNEY FOR <i>(Name):</i> _____	<b>FOR COURT USE ONLY</b>
<b>SUPERIOR COURT OF CALIFORNIA, COUNTY OF</b> STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME:	
PETITIONER/PLAINTIFF:  RESPONDENT/DEFENDANT:  OTHER PARENT/PARTY:	CASE NUMBER:  <i>(If applicable, provide):</i> HEARING DATE: HEARING TIME: DEPT.:
<b>PROOF OF PERSONAL SERVICE</b>	

1. I am at least 18 years old, not a party to this action, and not a protected person listed in any of the orders.
2. Person served *(name)*:
3. I served copies of the following documents *(specify)*:
  
4. By personally delivering copies to the person served, as follows:
 

a. Date:	b. Time:
c. Address:	
  
5. I am
 

a. <input type="checkbox"/> not a registered California process server.	d. <input type="checkbox"/> exempt from registration under Business & Profession Code section 22350(b).
b. <input type="checkbox"/> a registered California process server.	
c. <input type="checkbox"/> an employee or independent contractor of a registered California process server.	e. <input type="checkbox"/> a California sheriff or marshal.
6. My name, address, and telephone number, and, if applicable, county of registration and number *(specify)*:
  
7.  I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
8.  I am a California sheriff or marshal and I certify that the foregoing is true and correct.

Date:

\_\_\_\_\_  
 (TYPE OR PRINT NAME OF PERSON WHO SERVED THE PAPERS)

\_\_\_\_\_  
 (SIGNATURE OF PERSON WHO SERVED THE PAPERS)

ATTORNEY OR PARTY WITHOUT ATTORNEY ( <i>Name, State Bar Number and Address</i> )  TELEPHONE NO: _____ FAX NO. ( <i>Optional</i> ): _____ E-MAIL ADDRESS ( <i>Optional</i> ): _____ ATTORNEY FOR ( <i>Name</i> ): _____	FOR COURT USE ONLY    CASE NUMBER: _____
<input type="checkbox"/> PEOPLE OF THE STATE OF CALIFORNIA <input type="checkbox"/> PLAINTIFF/PETITIONER:  vs.  DEFENDANT/RESPONDENT: _____	
<b>REQUEST FOR AN INTERPRETER</b>	

**1. Case Type (*Please check applicable box*):**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Criminal                     | <input type="checkbox"/> Traffic   | <input type="checkbox"/> Juvenile Delinquency            |
| <input type="checkbox"/> Juvenile Dependency          | <input type="checkbox"/> Mental Health                                     | <input type="checkbox"/> Child Support Case              |
| <input type="checkbox"/> Family Law Domestic Violence | <input type="checkbox"/> Elder Abuse                                       | <input type="checkbox"/> Civil Harassment                |
| <input type="checkbox"/> Unlawful Detainer            | <input type="checkbox"/> Termination of Parental Relationship – Family Law | <input type="checkbox"/> Guardianship or Conservatorship |
| <input type="checkbox"/> Other: _____                 |  |  |

**2. Name of person needing an interpreter:** \_\_\_\_\_

- |                                    |  |   |
|------------------------------------|--|---|
| <input type="checkbox"/> Defendant | <input type="checkbox"/> Plaintiff       | <input type="checkbox"/> Witness for: _____ |
| <input type="checkbox"/> Minor     | <input type="checkbox"/> Parent/Guardian | <input type="checkbox"/> Party on Case      |

Requested by:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> District Attorney | <input type="checkbox"/> DPSS           | <input type="checkbox"/> Juvenile Defense Counsel |
| <input type="checkbox"/> DA Advocate       | <input type="checkbox"/> Probation      | <input type="checkbox"/> Party on Case            |
| <input type="checkbox"/> Defense Counsel   | <input type="checkbox"/> County Counsel | <input type="checkbox"/> Other: _____             |

**3. Date of Hearing:** \_\_\_\_\_ **Dept:** \_\_\_\_\_ **Estimate of time interpreter will be needed:** \_\_\_\_\_

- Half Day (*choose one*):  AM - 8 to 12  PM - 1 to 5  Full Day - 8 to 5  On-call - Any time  
 Estimated Length of Hearing (HRS/DAYS): \_\_\_\_\_

**4. Language being requested: (*A minimum of 48 hours needed for a Spanish and Sign Language Interpreter and 5 days for all other languages (Local Rule 1025).*)**

- |   |  |  |                                     |
|---|--|--|-------------------------------------|
| <input type="checkbox"/> Arabic   | <input type="checkbox"/> German            | <input type="checkbox"/> Lao                     | <input type="checkbox"/> Russian    |
| <input type="checkbox"/> Armenian East  | <input type="checkbox"/> Hungarian         | <input type="checkbox"/> Mandarin/Chinese        | <input type="checkbox"/> Samoan     |
| <input type="checkbox"/> Armenian West  | <input type="checkbox"/> Indonesian        | <input type="checkbox"/> Portuguese              | <input type="checkbox"/> Spanish*   |
| <input type="checkbox"/> Cantonese  | <input type="checkbox"/> Japanese          | <input type="checkbox"/> Punjabi                 | <input type="checkbox"/> Tagalog    |
| <input type="checkbox"/> Farsi  | <input type="checkbox"/> Khmer (Cambodian) | <input type="checkbox"/> Q'anjob'al (K'anjob'al) | <input type="checkbox"/> Thai       |
| <input type="checkbox"/> French   | <input type="checkbox"/> Korean            | <input type="checkbox"/> Romanian                | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Other: _____ (If requesting a language not listed above, please include country or region if known.) Country/Region: _____ |  |  |                                     |

\* Requests for an assigned Spanish interpreter to trials lasting one day or more must be made in advance.

**If the above hearing date is continued or taken off calendar, please cancel the request with the Courtroom Assistant or Court Services Coordinator no less than 24 hours in advance. If the attorney cancels the request for an interpreter less than 24 hours in advance of the hearing date, the attorney who requested the interpreter shall pay the cost incurred by the court for the interpreter.**

**Note:** Please complete Judicial Council form MC-410 *Request for Accommodations by Persons with Disabilities and Response* if you need an American Sign Language interpreter.

# INSTRUCTIONS FOR FILING

1. **FILL OUT** the documents
2. **MAKE COPIES** – You will need the original plus two more complete sets (copy each document 2 times).
3. **FILE** – Give the original plus the copies to the Clerk of the Court at the Family Law filing window. The clerk will keep the original and give you your copies back.
  - **FILE** - If an interpreter is needed, file form RI-IN007 (Request for Interpreter) along with your paperwork. Please request an interpreter as soon as possible to allow for processing.
4. **SERVE** – If the Respondent has not filed a Response in the case, the Request for Order must be served by personal service by someone other than you, at least 18 years of age at least 16 court days prior to the hearing date. If the Respondent has filed a Response in the case, service can be completed by mail by someone other than you, at least 18 years of age at least 21 calendar days prior to the hearing date.
5. **FILE** – You must file the Proof of Service at the Clerk’s Office (bring the original and 1 extra copy).
6. **ATTEND** your Child Custody Recommending Counseling Appointment, **if required**.
7. **ATTEND** your hearing.
8. **PREPARE** an Order After Hearing, **if necessary**.

**PRINT**

