

The Law Offices of Shelly B. West

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**MODIFICATION
INFORMATION SHEET**

Date of Consultation: _____ Referred by: _____
(today's date)

PETITIONER: (If you are filing a new case you are the Petitioner.)

Full Name: _____ Age: _____

Maiden Name: _____ Social Security Number: _____

Birthdate / Place: _____ D.L. No. & State _____

Home Address & County: _____

Telephone Numbers: (Work): _____ (Home): _____

Other numbers: (Cell): _____ (Fax): _____

Business Name: _____

Business Address: _____

email Address: _____

Salary/Income: _____

RESPONDENT: (If you are responding to a case that was filed against you, you are the Respondent.)

Full Name: _____ Age: _____

Maiden Name: _____ Social Security Number: _____

Birthdate / Place: _____ D.L. No. & State _____

Home Address & County: _____

Telephone Numbers: (Work): _____ (Home): _____

Business Address: _____

email Address: _____

Salary/Income: _____

Next of Kin: _____ Phone: _____

CHILDREN FROM THIS MARRIAGE UNDER 18:

Name	S.S. Number	Sex	Birthdate	Birthplace
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Temporary Orders Desired?
 Extraordinary Relief Desired?
 Request Award of Attorney's Fees?
 Waiver or Service?

Who is/are the child(ren) living with now and for what period of time: _____

What are you seeking to change? Check all that apply:

- Raise child support
- Lower child support
- Get health insurance for child(ren)
- Get dental insurance for child(ren)
- Obtain reimbursement for medical expenses
 - Who will pay _____ you _____ or the other party?
- Change visitation
 - More time with kids for you _____
 - More time with kids for other party _____
 - Change visitation to something else _____
- Change custody
 - Custody for you _____
 - Custody for other party _____
 - Change custody to joint custody _____
 - Change visitation to something else _____
- Domicile restriction
 - Lift it _____
 - Impose a domicile restriction _____
- Other changes. Please explain: _____

Have you been to court before in this matter? _____

When and Why? _____

Cause No. (Case No.) and County of case _____
 (Please provide the latest order, if any.)

NO. _____

IN THE MATTER OF
THE MARRIAGE OF

_____,
AND

§ IN THE DISTRICT COURT
§
§
§ _____ JUDICIAL DISTRICT
§
§ _____ COUNTY, TEXAS

AFFIDAVIT FOR UCCJEA INFORMATION

_____ appeared in person before me today and stated under oath:

"My name is _____. I am competent to make this affidavit. The facts stated in this affidavit are within my personal knowledge and are true and correct.

"I am the Petitioner in this case.

"The child's present whereabouts are _____.

"From the date of birth of the child OR for the prior five years until immediately preceding the date of this affidavit, the child(ren) has/have lived at the following addresses with the following person or persons:

1. Date: _____ – _____. (present)

Address: _____

Persons lived with: _____

2. Date: _____ – _____. (present)

Address: _____

Persons lived with: _____

3. Date: _____ – _____. (present)

Address: _____

Persons lived with: _____

"I have not participated, as a party or as a witness or in any other capacity, in any other proceeding concerning the custody of or visitation with the child in Texas or any other state.

"I do not know of any proceeding that could affect this proceeding, including proceedings for enforcement and proceedings relating to domestic violence, protective orders, termination of parental rights, and adoptions.

"I do not know of any person not a party to this proceeding who has physical custody of the child or claims rights of legal custody or physical custody of, or visitation with, the child."

_____, Affiant

SIGNED under oath before me on _____, 2005.

Notary Public, State of Texas

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IN THE DISTRICT COURT
 _____ JUDICIAL DISTRICT
 _____ COUNTY, TEXAS

FINANCIAL INFORMATION STATEMENT
(Required in All Financial Hearings)

<u>MONTHLY EXPENSES</u>	<u>MONTHLY EXPENSES (cont.)</u>
PRESENT	PRESENT
<u>HOUSING</u>	<u>YOUR CHILDREN</u>
House Mortgage/Rent _____	Child Care _____
Utilities _____	School Tuition, Fees _____
(Gas, water, etc.) _____	Lunches _____
Maintenance & Repair _____	Supplies _____
Other _____	Medical Expenses _____
<u>TRANSPORTATION</u>	(not covered by ins) _____
Car Payment/Lease _____	Drugs _____
Gas, Oil, Maintenance _____	Doctors, Dentists _____
Parking & Tolls _____	Grooming _____
<u>INSURANCE</u>	Entertainment _____
Auto _____	Sports, Lessons, etc. _____
Life _____	Other: _____
Medical _____	_____
Other _____	_____
<u>GROCERIES</u>	<u>TOTAL EXPENSES</u> _____
Food & Household Supplies _____	_____
<u>YOUR PERSONAL</u>	INCOME: (attach current pay stubs)
Work Expenses:	[] paid monthly [] paid semi-monthly
Lunches, etc. _____	[] paid weekly [] paid every two weeks
Dues, Fees, etc. _____	_____
Medical Expenses _____	<u>GROSS INCOME</u>
(not paid by ins):	<u>DEDUCTIONS</u>
Drugs _____	Withholding Tax _____
Doctors, Dentists _____	FICA _____
Clothing _____	Mandatory Retirement _____
Cleaning, Laundry _____	Medical Insurance _____
Grooming _____	Children _____
Entertainment _____	Other Family _____
Current Child Support _____	Life Insurance _____
Other: _____	Other _____
_____	<u>OTHER</u> _____
_____	<u>LIQUID ASSETS</u> _____
<u>CREDIT CARD/DEBTS</u>	_____
_____	I hereby certify that the answers to the above questions
_____	as listed are true and correct.
<u>Monthly Attorney Fees</u> _____	_____ Date _____ Signed _____

CAUSE NO. _____

IN THE MATTER OF (INTEREST OF)

§
§
§
§
§

IN THE DISTRICT COURT

OF DALLAS COUNTY, TEXAS

AND

_____ JUDICIAL DISTRICT

HEALTH INSURANCE AVAILABILITY FORM

*Attention: This information must be filed with the court BEFORE first hearing.
See TEX FAM CODE § 154.181(b).*

NAME OF PARTY: _____ MOVANT RESPONDENT

PARTY'S ATTORNEY (IF ANY): _____

BESIDE THE NAME OF EACH CHILD, CHECK ALL TYPES OF HEALTH INSURANCE OR HEALTH CARE BENEFITS CURRENTLY COVERING THE CHILD(REN). YOU MAY CHECK MORE THAN ONE SOURCE.

NAME	DOB	SSN	EMPLOYER PROVIDED					NONE
			FATHER'S	MOTHER'S	PRIVATE	CHIP	OTHER	
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR EACH INSURANCE SOURCE PLEASE LIST THE FOLLOWING INFORMATION:
(ATTACH ADDITIONAL FORMS FOR EACH SOURCE OF BENEFITS)

- A. NAME OF CARRIER _____
- B. GROUP POLICY ID NUMBER _____
- C. POLICYHOLDER NAME & ID NUMBER _____
- D. NAME OF COVERED CHILD _____

E. COST/MONTH OF COVERAGE [CHILD{REN} ONLY] \$ _____
(To determine coverage cost for child(ren), determine total cost for family coverage and subtract from this amount the cost to insure all covered individuals except the children.)

F. ARE YOU CURRENTLY PAYING THE PREMIUMS FOR LISTED MEDICAL BENEFITS? YES NO

STATE YOUR NET MONTHLY INCOME FROM YOUR FINANCIAL INFORMATION STATEMENT: \$ _____

SIGNATURE OF PARTY COMPLETING FORM

DATE

PRINTED NAME

