



A Practice Devoted to Divorce Financial Analysis

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FINANCIAL AFFIDAVIT

Name: _____

Date Prepared: ____/____/____

Table with 3 columns: Expense Category, Monthly Expenses, Annual Expenses. Rows include Home Expenses (Rent/Mortgage, Homeowners/Association Fees, Property Taxes, Telephone, Cell phone, Pager, Internet, Security System, Cable/Satellite, Electricity, Gas/Fuel Oil/Propane/Wood, Water/Sewer, Trash Removal, Grass Cutting/Fertilizing, Landscape Maintenance, Snow Removal, Exterminator, Gen'l Home Repairs/Maint./ Windows/Carpets, Home Improvements/Upgrades, Housecleaning, Miscellaneous Household, Total Home Expenses) and Food Expenses (Groceries, Snacks, Fast Foods, Restaurant Meals, Total Food Expenses).

Name : _____

| | Monthly Expenses | Annual Expenses |
|--|---------------------|--------------------|
| Entertainment/Recreation Expenses | | |
| Entertainment (excludes dining out) | \$ _____ | \$ _____ |
| Videos/CDs/DVDs | \$ _____ | \$ _____ |
| Movies and Theater | \$ _____ | \$ _____ |
| Hobbies for Self | \$ _____ | \$ _____ |
| Classes/Lessons (recreational) for Self | \$ _____ | \$ _____ |
| Vacations/Travel | \$ _____ | \$ _____ |
| Memberships/Clubs for Self | | |
| Total Entertainment/Rec. Expenses | \$ _____ | \$ _____ |

Medical (After Insurance – Excludes Children)

| | | |
|-------------------------------|-----------------|-----------------|
| Physicians | \$ _____ | \$ _____ |
| Dentist/Orthodontist | \$ _____ | \$ _____ |
| Optometrist/Glasses/Contacts | \$ _____ | \$ _____ |
| Prescriptions | \$ _____ | \$ _____ |
| Total Medical Expenses | \$ _____ | \$ _____ |

Insurance

| | | |
|-------------------------------------|-----------------|-----------------|
| Life | \$ _____ | \$ _____ |
| Health & Dental (Post Divorce) | \$ _____ | \$ _____ |
| Disability | \$ _____ | \$ _____ |
| Long Term Care | \$ _____ | \$ _____ |
| Home Insurance | \$ _____ | \$ _____ |
| Auto Insurance | \$ _____ | \$ _____ |
| Other Insurance (Boat, Umbrella,..) | \$ _____ | \$ _____ |
| Total Insurance Expenses | \$ _____ | \$ _____ |

Transportation Expenses for Self

| | | |
|--------------------------------------|-----------------|-----------------|
| Auto Payment | \$ _____ | \$ _____ |
| Fuel | \$ _____ | \$ _____ |
| Repair/Maintenance/Car Wash | \$ _____ | \$ _____ |
| Parking/Tolls | \$ _____ | \$ _____ |
| License | \$ _____ | \$ _____ |
| Total Transportation Expenses | \$ _____ | \$ _____ |

Name : _____

| | Monthly Expenses | Annual Expenses |
|--|------------------|-----------------|
| Total Monthly Expenses (Excluding Children) | \$ _____ | \$ _____ |
| Child-Related Expenses | | |
| Education/Tuition | \$ _____ | \$ _____ |
| School Supplies/Field Trips | \$ _____ | \$ _____ |
| Childcare - Work Related (After Tax Credit) | \$ _____ | \$ _____ |
| Childcare - Non-Work Related | \$ _____ | \$ _____ |
| Sports/Camps/Lessons | \$ _____ | \$ _____ |
| Hobbies/Toys/Games | \$ _____ | \$ _____ |
| School Meals/Luncheons | \$ _____ | \$ _____ |
| Clothing | \$ _____ | \$ _____ |
| Medical (Not Covered by Insurance) | \$ _____ | \$ _____ |
| Dentist/Orthodontist (Not Covered by Insurance) | \$ _____ | \$ _____ |
| Optometrist/Glasses/Contacts (Not Covered by Insurance) | \$ _____ | \$ _____ |
| Prescriptions (Not Covered by Insurance) | \$ _____ | \$ _____ |
| Allowances | \$ _____ | \$ _____ |
| Transportation | \$ _____ | \$ _____ |
| Miscellaneous | \$ _____ | \$ _____ |
| Total Child-Related Expenses | \$ _____ | \$ _____ |
| Total Monthly Expenses | \$ _____ | \$ _____ |

Name : _____

| | Monthly Expenses | Annual Expenses |
|--|-------------------------|------------------------|
| Total Monthly Expenses (Excluding Children) | \$ _____ | \$ _____ |
| Child-Related Expenses | | |
| Education/Tuition | \$ _____ | \$ _____ |
| School Supplies/Field Trips | \$ _____ | \$ _____ |
| Childcare - Work Related (After Tax Credit) | \$ _____ | \$ _____ |
| Childcare - Non-Work Related | \$ _____ | \$ _____ |
| Sports/Camps/Lessons | \$ _____ | \$ _____ |
| Hobbies/Toys/Games | \$ _____ | \$ _____ |
| School Meals/Luncheons | \$ _____ | \$ _____ |
| Clothing | \$ _____ | \$ _____ |
| Medical (Not Covered by Insurance) | \$ _____ | \$ _____ |
| Dentist/Orthodontist (Not Covered by Insurance) | \$ _____ | \$ _____ |
| Optometrist/Glasses/Contacts (Not Covered by Insurance) | \$ _____ | \$ _____ |
| Prescriptions (Not Covered by Insurance) | \$ _____ | \$ _____ |
| Allowances | \$ _____ | \$ _____ |
| Transportation | \$ _____ | \$ _____ |
| Miscellaneous | \$ _____ | \$ _____ |
| Total Child-Related Expenses | \$ _____ | \$ _____ |
| Total Monthly Expenses | \$ _____ | \$ _____ |