



New Jersey Judiciary
Confidential Litigant Information Sheet (R. 5:4-2(g))

To assure accuracy of court records - To be filled out by Plaintiff or Defendant or Attorney
 Collection of the following information is pursuant to *N.J.S.A. 2A:17-56.60* and *R 5:7-4*.
Confidentiality of this information must be maintained.

Please complete the entire form, leaving no blank spaces. If something does not apply to you, enter "N/A". This form is confidential and will not be shared with the other party.

Docket Number:	CS Number:	Do you have an active Domestic Violence Order with the other party in this case? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Plaintiff					Defendant						
Name (last, first, middle Initial) Wife					Name (last, first, middle Initial) Husband						
Social Security Number	Date of Birth	Place of Birth			Social Security Number	Date of Birth	Place of Birth				
Address: Street					Address: Street						
City	State	Zip			City	State	Zip				
Plaintiff Telephone Number			Employer Telephone Number		Defendant Telephone Number			Employer Telephone Number			
Employer Name (or other income source)					Employer Name (or other income source)						
Employer Address: Street					Employer Address: Street						
City	State	Zip			City	State	Zip				
Professional, Occupational, Recreational Licenses (include types and license numbers)					Professional, Occupational, Recreational Licenses (include types and license numbers)						
Driver's License Number			State of Issuance		Driver's License Number			State of Issuance			
Sex Male	Race/Ethnicity	Height	Weight	Eyes	Hair	Sex Female	Race/Ethnicity	Height	Weight	Eyes	Hair
Auto: License Plate	State	Make	Model	Year	Auto: License Plate	State	Make	Model	Year		
Attorney Name					Attorney Name						
Attorney Address: Street					Attorney Address: Street						
City	State	Zip			City	State	Zip				

Name (last, first, middle initial)	Date of Birth	Race	Sex	Social Security Number	Place of Birth

Health Coverage for Children - available through parent filling out this form (Plaintiff / Defendant)

Health Care Provider	Policy #	Group #
Health Care Provider	Policy #	Group #
Health Care Provider	Policy #	Group #

I certify that the foregoing statements made by me are true to the best of my knowledge. I am aware that if any of the foregoing statements made by me are wilfully false, I am subject to punishment.

_____	_____
Date	Signature

Revised: 10/2012.

REQUIRED ATTACHMENTS

1. A full and complete copy of your last federal and state income tax returns with all schedules and attachments.
2. Your last calendar year's W-2 statement and 1099's, K-1 Statement.
3. Your three most recent pay stubs.
4. Bonus information including, but not limited to, percentage overrides, timing of payments, etc.; the last three statements of such bonuses, commissions, etc.
5. Your most recent corporate benefit statement or a summary thereof, showing the nature, amount and status of retirement plans, savings plans, income deferral plans, insurance benefits, etc.

Date of this Statement:	
Date of Divorce:	
Date of Prior Statements (if any)	
Your Birth date:	
Spouse's Birth date:	
Date of Marriage:	
Date of Separation:	
Date of Complaint:	

Children from this Marriage:

Child #1

Full Name	
Street Address	
City	
State	
Zip Code	
Date of Birth:	
Child's Guardian	

Child #2:

Full Name	
Street Address	
City	
State	
Zip Code	
Date of Birth:	
Child's Guardian	

PART B - MISCELLANEOUS INFORMATION

Information about Your Employer (Provide Name and Address of Business, if Self-Employed):

Employer's Name	
Street Address	
City	
State	
Zip Code	

Additional Identifying Information about yourself:

Social Security Number	
State Driver's License Number	
Eye Color	
Place of Birth	
Sex	
Height	
Weight	
Race	
Hair	

PART C - INCOME INFORMATION

Complete this section for yourself and (if known) for spouse:

LAST YEAR'S INCOME

	Yours	Joint	Spouse or Former Spouse
Gross earned income last calendar year (year _____)			
Unearned income (same year)			
Total Income Taxes paid on above income (including Federal, State, F.I.C.A. and S.U.I.). If Joint Return, use middle column			

PRESENT EARNED INCOME

	Yours	Spouse
Average Gross weekly income (based on last 3 pay periods) (compute at 4.3 weeks per month) Commissions and bonuses, etc., are: ___ included ___ not included ___ not paid to you		
Deductions per week: check all types of withholdings ___ Federal ___ State ___ F.I.C.A. ___ S.U.I. ___ Other: _____		

Is there a wage execution in connection with support?

Yes No

If yes, explain.

Has a dependent child of yours received income from social security, SSI or other government program during either the current or immediate past calendar year?

Yes No

If yes, state the dates(s) or receipt and gross/net amounts received.

PART D - MONTHLY EXPENSES

(Computed at 4.3 wks/mo.) Joint marital life style should reflect standard of living established during marriage, but not repeat those income deductions listed on Part C.

SCHEDULE A: SHELTER

If Tenant:	Joint marital life style How many children? _____	Yours and children residing with you How many children? _____
Rent		
Heat (if not furnished)		
Electric & Gas (if not furnished)		
Renter's Insurance		
Parking (at apartment)		
Other Charges (Itemize)		

If Homeowner:	Joint marital life style How many children? _____	Yours and children residing with you How many children? _____
Mortgage		
Real Estate Taxes (unless included with mortgage payment)		
Homeowners Insurance (unless included with mortgage payment)		
Other Mortgages or Home Equity Loans		
Heat (unless electric or gas)		
Electric & Gas		
Water and Sewer		
Garbage Removal		

If Homeowner:	Joint marital life style How many children? _____	Yours and children residing with you How many children? _____
Snow Removal		
Lawn Care		
Maintenance		
Repairs		
Other Charges (Itemize)		

Tenant or Homeowner:	Yours and children residing with you How many children? _____	Joint marital life style How many children? _____
Telephone		
Mobile/Cellular Telephone		
Service Contracts on Equipment		
Cable TV		
Plumber/Electrician		
Equipment and furnishings		
Internet Charges		
Other (Itemize)		

SCHEDULE B: TRANSPORTATION

Auto Payment		
Auto Insurance (number of vehicles __)		
Registration, License		
Maintenance		
Fuel and Oil		
Commuting Expenses		
Other Charges (Itemize)		

SCHEDULE C: PERSONAL

Food at Home and household supplies		
Prescription Drugs		
Non-prescription drugs, cosmetics, toiletries and sundries		
School Lunch		
Restaurants		
Clothing		

Dry Cleaning, Commercial Laundry		
Hair Care		
Domestic Help		
Medical (exclusive of psychiatric)*		
Eye Care*		
Psychiatric/psychological/counseling*		
Dental (exclusive of orthodontic)*		
Orthodontic*		
Medical Insurance (hospitalization etc.)*,		
Club Dues and Memberships		
Sports and Hobbies		
Camps		
Vacations		
Children's Private School Costs		
Children's College Costs		
Parent's Educational Costs		
Children's Lessons (dancing, music, sports, etc.)		
Babysitting		
Day-Care Expenses		
Entertainment		
Alcohol and Tobacco		
Newspapers and Periodicals		
Gifts		
Contributions		
Payments to Non-Child Dependents		
Prior Existing Support Obligations		
(This family)		
(other families - specify)		
Tax Reserve (not listed elsewhere)		
Life Insurance		
Savings/investment		
Debt Service (exclusive of mortgage)		
Parenting Time Expenses		
Pet/Veterinarian Expenses		
Professional Expenses (other than this proceeding)		

Statement of Assets

Description	Who Owns it? (H, W, J)*	Date of purchase /acquisition	If this should be exempt from equitable distribution, state reason?	Value (\$)	Date of Evaluation
Real Property					
Bank Accounts					
Vehicles					
Tangible Personal Property					
Stocks and Bonds					

Pension, Profit sharing, Retirement Plans, IRAs, 401Ks, etc. (list each, employer)					
Businesses, Partnerships, Professional Practices					
Life Insurance (Cash surrender value)					
Loan Receivable					
Other (Specify)					

* H = Husband W = Wife J = Joint

Statement of Liabilities

Description	Responsible Party? (H, W, J)*	If this should be exempt from equitable distribution, state reason?	Monthly Payment	Total Owed	Date of Evaluation
Real Estate Mortgage					
Other Long Term Debts					
Revolving Charges					
Other Short Term Debts					
Contingent Liabilities					

* H = Husband W = Wife J = Joint

AUTOMOBILE INSURANCE

Name and address of company	
Policy Number	
Policy Exp. Date	
Vehicles Covered	
Coverage Limits	
Lawsuit Threshold	
Umbrella Coverage	
Drivers	
Lien Holder	
Use of vehicle	<input type="checkbox"/> Personal <input type="checkbox"/> Business <input type="checkbox"/> Personal and Business

HOMEOWNERS INSURANCE

Name and address of Company	
Policy number/Expiration date	
Covered residence	
Umbrella coverage	
Mortgagee name and address	
riders	

LIFE INSURANCE

Name and address of company (Policy #1)	
Customer Service Address	
Policy Number	
Beneficiary/Insured/Owner	
Face Amount	
Policy Term	

Name and address of company (Policy #2)	
Customer Service Address	
Policy Number	
Beneficiary/Insured/Owner	
Face Amount	
Policy Term	

HEALTH INSURANCE

Name of Insured						
Name and address of company						
ID Number						
Group Number						
Coverage Type	Single	<input type="checkbox"/>	Optical	<input type="checkbox"/>	Dental	<input type="checkbox"/>
	Parent-Child	<input type="checkbox"/>	Hospital	<input type="checkbox"/>	Drug	<input type="checkbox"/>
	Family	<input type="checkbox"/>	Major Medical	<input type="checkbox"/>	Diagnostic	<input type="checkbox"/>
Made available through	employment	<input type="checkbox"/>				
	personally obtained	<input type="checkbox"/>				