

STATE OF DELAWARE
Office of Management and Budget
Statewide Benefits Office

STATEMENT OF SUPPORT

Employee/Pensioner Name: _____ Employee/Pensioner ID#: _____
 Dependent Name: _____ Date: _____

TYPE OF EXPENSE	TOTAL COST OF SUPPORT	AMOUNT PAID BY DEPENDENT	AMOUNT PAID BY MOTHER	AMOUNT PAID BY FATHER
Lodging Furnished	\$	\$	\$	\$
Food**				
Medical & Dental Care				
Transportation				
Clothing				
Contributions				
Entertainment & Recreation				
Tuition (Room & Board, etc.)				
Other: (list)				
TOTALS	\$	\$	\$	\$

1. Is anyone else (e.g., former spouse or natural parent) providing support on behalf of this child? Yes No
 - a. Name of person providing support: _____
 - b. Relationship: _____
 - c. Amount of support provided per month: _____
 - d. By Court Order? Yes No
2. Does this person provide coverage for:
 - a. Health? Yes No Insurance Provider's Name: _____
Policyholder's I.D. #: _____
 - b. Prescription? Yes No Insurance Provider's Name: _____
Policyholder's I.D. #: _____
 - c. Dental? Yes No Insurance Provider's Name: _____
Policyholder's I.D. #: _____
 - d. Vision? Yes No Insurance Provider's Name: _____
Policyholder's I.D. #: _____

We certify that the figures above are correct to the best of our knowledge.

Employee's/Pensioner's Signature	Date
Dependent's (Residential) Street address	Date
Dependent's City, State and Zip Code	Date

A form must be completed for each child regardless of age.
Employee must sign form.
New form must be completed if information changes.
HR/Benefits Office must maintain original on file.