

Name of Person Filing Document: _____
 Your Address: _____
 Your City, State, and Zip Code: _____
 Your Telephone Number: _____
 Attorney Bar Number (if applicable): _____
 Representing Self (Without Attorney) OR Attorney for Petitioner OR Respondent

For Clerk's Use Only

SUPERIOR COURT OF ARIZONA IN MARICOPA COUNTY

 Name of Petitioner/Plaintiff

Case Number: _____

 Name of Respondent/Defendant

SUPPLEMENTAL APPLICATION FOR FURTHER DEFERRAL OR WAIVER OF COURT FEES AND/OR COSTS

STATE OF ARIZONA)
 COUNTY OF MARICOPA) ^{SS}

STATEMENTS MADE TO THE COURT UNDER OATH OR AFFIRMATION. I swear or affirm that the information in this application is true and correct. I make this statement under the penalty of prosecution for perjury if it is determined that I did not tell the truth.

1. I am requesting a further deferral or waiver of any unpaid fees and costs in my case.

The basis for the request is:

1. **WAIVER: I am permanently unable to pay. My income and liquid assets are insufficient or barely sufficient to meet the daily essentials of life and unlikely to change in the foreseeable future.**

OR

2. **FURTHER DEFERRAL:**
 a. I receive governmental assistance from the state/federal program(s) checked below:
 Temporary Assistance for Needy Families (TANF) Food Stamps
 Supplemental Security Income (SSI) General Assistance (GA)

If you checked either boxes 1 or 2a., you must complete the Financial Questionnaire. You must submit proof that you receive governmental assistance. If you are submitting this application by mail or a third party, you must attach a photocopy of that proof.

OR

b. **My income is insufficient or is barely sufficient to meet the daily essentials of life, and includes no allotment that could be budgeted for the fees and costs that are required to gain access to the court.**

NOTE: To determine whether income is insufficient or barely sufficient, the court will review your income and expenses. Among the factors the court may consider are:

1. Whether your gross income as computed on a monthly basis is 150% or less of the current federal poverty level. Gross monthly income includes your share of community property income if available to you.
2. Although your income is greater than 150% of the poverty level, you have proof of extraordinary expenses, including medical expenses, costs of care for elderly or disabled family members or other expenses that the court finds are extraordinary and that reduce your gross monthly income to at or below 150% of the poverty level.

OR

c. I do not have the money to pay court filing fees and/or costs now. I can pay the filing fees and/or costs at a later date. Explain: _____

If you checked either boxes 2b. or 2c., you must complete the Financial Questionnaire.

FINANCIAL QUESTIONNAIRE

SUPPORT RESPONSIBILITIES: List all persons you support (including those for whom you pay child support and/or spousal maintenance/support):

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____

STATEMENT OF INCOME AND EXPENSES

ASSISTANCE: I receive assistance from:

- Arizona Health Care Cost Containment System (AHCCCS)
- Arizona Long Term Care System (ALTUS)
- Other (explain): _____

MONTHLY INCOME: My monthly income is:

Monthly gross income: \$ _____
 Employer name: _____
 Employer address: _____
 Employed since (month/year): _____
 Other current monthly income, including spousal Maintenance/support, retirement, rental, interest, pensions, scholarships, grants, royalties, lottery winnings (explain amount and source): \$ _____

My spouse's monthly gross income (if available to me): \$ _____

TOTAL MONTHLY INCOME: \$ _____

MONTHLY EXPENSES AND DEBTS: My monthly expenses and debts are:

	PAYMENT AMOUNT	LOAN BALANCE
Rent/Mortgage payment	\$ _____	\$ _____
Car Payment	\$ _____	\$ _____
Credit Card Payments	\$ _____	\$ _____
Other payments and debts	\$ _____	\$ _____
Explain:		
Food/Household supplies	\$ _____	
Utilities/Telephone	\$ _____	
Clothing	\$ _____	
Medical/Dental/Drugs	\$ _____	
Health Insurance	\$ _____	
Nursing care	\$ _____	
Laundry	\$ _____	
Child Support	\$ _____	
Child Care	\$ _____	
Spousal Maintenance	\$ _____	
Car Insurance	\$ _____	
Gasoline/Bus Fare	\$ _____	
Contributions to Employer or Other Retirement Account	\$ _____	
TOTAL MONTHLY PAYMENTS		\$ _____

STATEMENT OF ASSETS: List only those assets available to you and accessible without financial penalty. Equity is defined as market value minus any liens or loans.

	ESTIMATED VALUE
Cash and Bank Accounts	\$ _____
Credit Union Accounts	\$ _____
Equity in:	
1. Home	\$ _____
2. Other property	\$ _____
3. Cars/other vehicles	\$ _____
Other, including stocks, bonds, etc.	\$ _____
Retirement Accounts	\$ _____
TOTAL ASSETS:	\$ _____

EXTRAORDINARY EXPENSES: For example, unusual medical needs, financial hardship, costs of care of elderly or disabled family members. (Proof must be submitted.)

DESCRIPTION	AMOUNT
_____	\$ _____
_____	\$ _____
TOTAL EXTRAORDINARY EXPENSES:	\$ _____

SIGNATURE UNDER PENALTY OF PERJURY

Today's Date: _____ Signature: _____
 Print your Name: _____