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FL-421

PETITIONER/PLAINTIFF:	CASE NUMBER:
RESPONDENT/DEFENDANT:	
OTHER PARENT:	

PAYMENT HISTORY FOR *(check one)*:

☐ Child ☐ Spousal ☐ Family ☐ Medical ☐ Unreimbursed child care
☐ Unreimbursed medical ☐ Other *(specify)*:

	Year _____		Year _____		Year _____	
	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						
TOTAL						

	Year _____		Year _____		Year _____	
	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID
January						
February						
March						
April						
May						
June						
July						
August						
September						
October						
November						
December						
TOTAL						

Form Approved for Optional Use
Judicial Council of California
FL-421 [Rev. July 1, 2003]

PAYMENT HISTORY ATTACHMENT
(Family Law—Governmental—Uniform Parentage Act)

Family Code, §§ 5230.5, 17524 (a), 17526(c)

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INSTRUCTIONS FOR COMPLETING PAYMENT RECORD

You must complete a separate *Payment History Attachment* form for each type of support paid. Enter the year, list the amount ordered, and the amount paid for each month during that year. If the amounts repeat in a column, you can use an arrow as shown in the example below. Add the amounts in each column to get the yearly totals. Enter the totals at the bottom.

Attach additional sheets and supporting documents (bills, receipts, and other proof of expense) as necessary.

[X] Child

	Year 2000		Year 2001	
	AMOUNT ORDERED	AMOUNT PAID	AMOUNT ORDERED	AMOUNT PAID
January	100	0	100	100
February				0
March				
April		100		100
May		100		0
June		100		
July		0		
August				100
September				100
October		100		0
November				
December				
TOTAL	**1,200**	**600**	**1,200**	**400**

[X] Spousal

	AMOUNT ORDERED	AMOUNT PAID
January	100	0
February		
March		
April		100
May		100
June		100
July		0
August		
September		
October		100
November		
December		
TOTAL	**1,200**	**600**

UNREIMBURSED CHILD CARE, MEDICAL, OR OTHER EXPENSES:

You must complete a separate *Payment History Attachment* form for each type of unreimbursed expense. If you have more than one bill, receipt, and other proof of expense per month use an additional declaration page (form MC-031) or separate page. **1.)** Itemize each expense; **2.)** attach proof of bill or payment; **3.)** mark each bill or payment with an Exhibit # _____; **4.)** group the bills, receipts, and other proof of expense in chronological order for each month; and **5.)** enter the total bills, receipts, and other proof of expense for each month. If your court order did not state a specific due date for reimbursement, then include that amount in the month that the expense was incurred.

[X] Unreimbursed child care expenses

Year 2001

	AMOUNT ORDERED	AMOUNT PAID
January	50% ($200)	0
February	50% ($200)	100
March	50% ($200)	0
April	50% ($200)	50
May		
June		
July		
August		
September		
October		
November		
December		
TOTAL	**$400**	**150**

[X] Unreimbursed medical expenses

Year 2001

	AMOUNT ORDERED	AMOUNT PAID
January	50% ($200)	0
February		
March	50% ($200)	0
April	50% ($75)	0
May		
June		
July		
August		
September		
October		
November		
December		
TOTAL	**$237.50**	**0**

Form MC-031

Petitioner/Plaintiff Defendant/Respondent	CASE NUMBER

I request reimbursement for 50% of these expenses, which are supported by copies of bills, receipts, and other proof of expense.

01/04/01	Dr. Adams	$45.00	Exhibit A
01/08/01	Dr. Lee, D.D.S.	$155.00	Exhibit B
02/15/01	AB X-ray Inc.	$200.00	Exhibit C
04/26/01	Kids Therapy	$75.00	Exhibit D

Child care expenses:

01/02	ABC School	50% ($200)	Exhibit E
02/02	ABC School	50% ($200)	
03/02	ABC School	50% ($200)	
04/02	ABC School	50% ($200)	

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

(TYPE OR PRINT NAME) (SIGNATURE OF DECLARANT)

Form MC-031 **ATTACHED DECLARATION**

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