

Phone:

Fax:

Application for Child or Spousal Support Services

(Please print clearly)

Name of applicant _____

Social Security Number (SSN) _____

Name of other party _____

**I request child/spousal support services under Title IV-D of the Social Security Act, as amended,
from _____ County Domestic Relations Section.**

Applicant Signature

Date

In accordance with Section 7(b) of the Privacy Act, you are hereby notified that disclosure of your Social Security number is mandatory based on Section 466(a)(13) of the Social Security Act [42 U.S.C. 666(a)(13)], Pennsylvania Consolidated Statutes (Pa C.S.) §4304.1 and §4353(a.2). Additionally, you are notified that this information will be used by the Title IV-D program to locate individuals for the purpose of establishing paternity and establishing, modifying, and enforcing support obligations.

FOR OFFICE USE ONLY

Date rec'd in DRS _____

TANF NON-TANF IV-E

Phone:

Fax:

FOR OFFICE USE ONLY

Plaintiff Name: _____

Defendant Name: _____

Docket Number: _____

PACSES Case Number: _____

Other State ID Number: _____

Intake Information Questionnaire/Data Sheet

(Please print clearly)

PLAINTIFF'S/CARETAKER'S INFORMATION: Relationship to Children: _____

Name (Last, First, Middle) _____

Alias _____ Mother's Name (if not Plaintiff) _____

Address _____

City _____ State _____ Zip Code _____ County _____

Physical Description: Ht. _____ Wt. _____ Eyes _____ Hair _____ Race _____

Home Phone () _____ SSN _____

Business Phone () _____ DOB ____ / ____ / ____

Mobile Phone () _____

Email Address _____

Mother's Maiden Name _____

Father's Name _____

City, State and Country of Birth _____

Plaintiff's Attorney _____

Plaintiff's Attorney Address _____

Employer Name _____ Net Pay \$ _____ per _____

Employer Address _____

Employer Phone () _____

Medical Insurance Carrier Name _____ Policy # _____

Medical Insurance Carrier Address _____

Carrier Phone () _____

Marital Status with respect to Defendant: __ Divorced __ Married __ Separated __ Single

Date Married ____ / ____ / ____ Separated ____ / ____ / ____ Divorced ____ / ____ / ____

Place of Marriage _____ Place of Divorce _____

Address of Last Marital Domicile _____

PLAINTIFF'S/CARETAKER'S INFORMATION (continued)

Relative or Friend Name _____ Relationship _____

Relative or Friend Address _____

Relative or Friend Phone Number (____) _____

CHILDREN'S INFORMATION (Defendant's children only)

1. NAME (Last, First, Middle) SSN DOB AGE SEX PATERNITY ESTABLISHED?

YES OR NO

Mother's Maiden Name

Father's Name

Hospital of Birth

City, State and Country of Birth

2. NAME (Last, First, Middle) SSN DOB AGE SEX PATERNITY ESTABLISHED?

YES OR NO

Mother's Maiden Name

Father's Name

Hospital of Birth

City, State and Country of Birth

3. NAME (Last, First, Middle) SSN DOB AGE SEX PATERNITY ESTABLISHED?

YES OR NO

Mother's Maiden Name

Father's Name

Hospital of Birth

City, State and Country of Birth

4. NAME (Last, First, Middle) SSN DOB AGE SEX PATERNITY ESTABLISHED?

YES OR NO

Mother's Maiden Name

Father's Name

Hospital of Birth

City, State and Country of Birth

DEFENDANT'S INFORMATION (continued)

Medical Insurance Carrier Name _____ Policy # _____

Medical Insurance Carrier Address _____

_____ Carrier Phone (____) _____

Relative or Friend Name _____ Relationship _____

Relative or Friend Address _____

Relative or Friend Phone Number (____) _____

ASSISTANCE/EXISTING SUPPORT ORDER INFORMATION:

Is(Are) the child(ren) a subject of any custody action? Y N

If Yes, list child(ren)'s name(s): _____

Are you receiving cash or medical assistance? Y N Applying? Y N

Are you receiving child care subsidy? Y N

Your Welfare Case # _____

Existing support order: Y N Case # _____ County _____ State _____

Amount for Spouse: \$ _____ Per month

Amount for Child(ren): \$ _____ Per month

Amount for Family (Spouse and Child[ren]): \$ _____ Per month

I verify that the statements in this document are true and correct to the best of my knowledge. I understand that any false statement is subject to penalty in 18 Pa. C.S. § 4904 relating to unsworn falsification to authorities.

Date

Plaintiff/Caretaker Signature

FOR OFFICE USE ONLY: (Circle correct choice)

BENEFICIARY TYPE: TANF NON-TANF IV-E

FEE PAID: Y N N/A