

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 _____

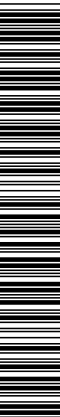
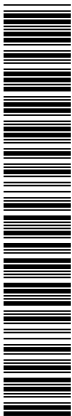
Carrier Phone () _____

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

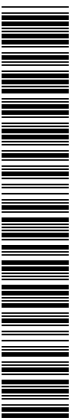
Hospital of Birth City, State and Country of Birth

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



CHILDREN'S INFORMATION (Continued)

5. 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 _____

6. 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

Name (Last, First, Middle) _____

Maiden Name/Alias _____

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 _____

Defendant's Attorney _____

Defendant's Attorney Address _____

Employer Name _____ Net Pay \$ _____ per _____

Employer Address _____

Employer Phone () _____



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

