WESTMORELAND COUNTY DOMESTIC RELATIONS

PHONE: 1-800-561-5022 FAX: (724) 830-3256

DATE: ________________

FOR OFFICE USE ONLY

Plaintiff Name: ____________________
Defendant Name: ___________________
Docket Number: ____________________
PACSES Case Number: _____________
Other State ID Number: _____________

Intake Information Questionnaire/Data Sheet

PLAINTIFF'S/CARETAKER'S INFORMATION:

Relationship to Children: ___________

Name (Last, First, Middle) ____

Maiden Name/Alias ____

Address ____

City ________________ State _____ Zip Code ___________ County _______________

SSN __________________ D/O/B _______/_____/______ Telephone (___)__________

Physical Description: Ht. ______ Wt. __________ Eyes _______ Hair _________ Race ______

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 (____)_____________

Martial Status with respect to Defendant ___ Divorced __ Married __ Separated ___Single

Date Married _____/____/____ Separated ____/____/_____ Divorced ____/_____/______

Place of Marriage ______________________ Place of Divorce ______________________

Relative or Friend Name __________________________ Relationship ___________________

Relative or Friend Address ____

Relative or Friend Phone Number (_____)____

Intake Information Questionnaire/Data Sheet

CHILDREN'S INFORMATION (Defendant's children only)

NAME (Last, First, Middle)	SSN	DOB	AGE	SEX	PATERNITY ESTABLISHED
____________________	__________	________	______	____	YES OR NO
____________________	__________	________	______	____	YES OR NO
____________________	__________	________	______	____	YES OR NO
____________________	__________	________	______	____	YES OR NO
____________________	__________	________	______	____	YES OR NO
____________________	__________	________	______	____	YES OR NO

DEFENDANT'S INFORMATION

Name (Last, First, Middle) ____

Maiden Name/Alias ____

Address ____

City __________________ State ______ Zip Code ____________ County ________________

SSN ___________________ D/O/B ________/_____/_______ Telephone (___)___________

Physical Description: Ht. _______ Wt. ___________ Eyes ________ Hair __________ Race _______

Defendant's Attorney ____

Defendant's Attorney Address ____

Employer Name ________________________________ Net Pay $____________ per ___________

Employer Address ____

____Employer Phone (_____)_____________

Medical Insurance Carrier Name _________________________ Policy #______________________

Medical Insurance Carrier Address ____

____ Carrier Phone (____)______________

DEFENDANT'S INFORMATION, continued

Relative or Friend Name ________________________________ Relationship _____________

Relative or Friend Address ____

____

Relative or Friend Phone Number (_____)____

Are you receiving case or medical assistance? Y N Applying? 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 Petitioner's Name

FOR OFFICE USE ONLY: (Circle correct choice)

BENEFICIARY TYPE: AFDC NON-AFDC IV E

FEE PAID: Y N N/A

IF THIS IS A PETITION TO MODIFY THE SUPPORT ORDER, PLEASE DESCRIBE BRIEFLY THE REASONS FOR SEEKING A MODIFICATION:

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