

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)

DEMOGRAPHICS

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 _____

DOB ____ / ____ / ____ SSN _____

Your Mother's Maiden Name _____

Your Father's Name _____

City, State and Country of Your Birth _____

DEFENDANT'S INFORMATION

Name (Last, First, Middle) _____

Maiden Name/Alias _____

Address _____

City _____ State _____ Zip Code _____ County _____

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

DOB ____ / ____ / ____ SSN _____

Mother's Maiden Name _____

Father's Name _____

City, State and Country of Birth _____



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

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

YES OR NO

Mother's Maiden Name Father's Name

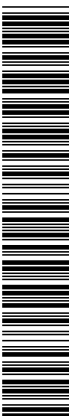
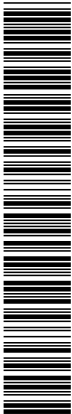
Hospital of Birth City, State and Country of Birth

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



CONTACT INFO

PLAINTIFF'S CONTACT INFORMATION:

Home Phone () _____

Mobile Phone () _____

Business Phone () _____

Email Address _____

DEFENDANT'S CONTACT INFORMATION:

Home Phone () _____

Mobile Phone () _____

Business Phone () _____

Email Address _____

PLAINTIFF'S RELATIVE / FRIEND CONTACT INFORMATION:

Relative or Friend Name _____ Relationship _____

Relative or Friend Address _____

Relative or Friend Phone Number () _____

DEFENDANT'S RELATIVE / FRIEND CONTACT INFORMATION:

Relative or Friend Name _____ Relationship _____

Relative or Friend Address _____

Relative or Friend Phone Number () _____

EMPLOYER INFO

PLAINTIFF'S EMPLOYER INFORMATION:

Employer Name _____ Net Pay \$ _____ per _____

Employer Address _____

Employer Phone () _____

DEFENDANT'S EMPLOYER INFORMATION:

Employer Name _____ Net Pay \$ _____ per _____

Employer Address _____

Employer Phone () _____

ATTORNEY INFO

PLAINTIFF'S ATTORNEY INFORMATION:

Plaintiff's Attorney _____

Plaintiff's Attorney Address _____

DEFENDANT'S ATTORNEY INFORMATION:

Defendant's Attorney _____

Defendant's Attorney Address _____

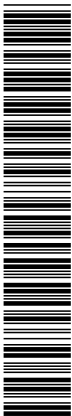
INSURANCE INFO

PLAINTIFF'S INSURANCE INFORMATION

Medical Insurance Carrier Name _____ Policy # _____

Medical Insurance Carrier Address _____

Carrier Phone () _____



DEFENDANT'S INSURANCE INFORMATION

Medical Insurance Carrier Name _____ Policy # _____
Medical Insurance Carrier Address _____
Carrier Phone () _____

MARITAL / PATERNITY INFO

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 _____

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

Do you have any concern for family violence? Y N

Do you have a need to keep your address confidential? Y N

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

