In the Court of Common Pleas of **County, Pennsylvania**

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 _____

SSN _____ DOB ___/___/___ Telephone (___) _____

Physical Description: Ht.____ Wt.____ Eyes_____ Hair_____ Race _____

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 _____

_____

Service Type

Form IN-002
Worker ID

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 _____

SSN _____ DOB / / Telephone ( ) _____

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

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 ( ) _____

Service Type

Form IN-002
Worker ID

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