Trumbull County Common Pleas Court
Domestic Relations Division
CHILD/SPOUSAL SUPPORT INFORMATION SHEET
(Note: You must attach appropriate order & IV-D application for processing)

CUSTODIAL PARENT/PAYEE: _____
First Middle Last

CASE NO:_____ RACE: _____ ON WELFARE:_____ MALE or FEMALE

S.S. No: _____/_____/_____ D.O.B. _____/_____/_____ PHONE:_____

ADDRESS: _____
No. Street City State Zip Code

EMPLOYER: _____ PHONE: _____

EMPY.ADDR: _____
No. Street City State Zip Code

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NON-CUSTODIAL PARENT/PAYOR: _____
First Middle Last

S.S. No. _____/_____/_____ D.O.B. _____/_____/_____ RACE: _____ MALE or FEMALE

ADDRESS: _____ PHONE:_____
No. Street City State Zip Code

EMPLOYER: _____ PHONE: _____

EMPY.ADDR: _____
No. Street City State Zip Code

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CHILD(REN)

NAME:_____ D.O.B. _____/_____/_____ RACE: _____
First Middle Last
S.S. No._____/_____/_____ MALE or FEMALE

NAME: _____ D.O.B. _____/_____/_____ RACE: _____
First Middle Last
S.S. No. _____/_____/_____ MALE or FEMALE

NAME: _____ D.O.B. _____/_____/_____ RACE: _____
First Middle Last
S.S. No. _____/_____/_____ MALE or FEMALE

(OVER)

NAME: _____ D.O.B. _____/_____/_____ RACE: _____
First Middle Last

S.S. No. _____/_____/_____ MALE or FEMALE

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EFFECTIVE DATE: _____ TOTAL AMOUNT OF ORDER: $_____

CHILD SUPPORT AMOUNT: _____ SPOUSAL SUPPORT AMOUNT: _____

ARREARGE AMOUNT: _____ ORDERED AMOUNT ON ARREARS: _____

FREQUENCY OF WAGES: _____ JUDGE ASSIGNED: _____

NON-CUSTODIAL PARENT'S ATTORNEY: _____ PHONE:_____

CUSTODIAL PARENT'S ATTORNEY: _____ PHONE:_____

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MEDICAL INSURANCE INFORMATION

PARTY ORDERED TO INSURE CHILD(REN): CUSTODIAL PARENT_____ NON-CUSTODIAL _____

WHO IS PRIMARY INSURER?: CUSTODIAL PARENT _____ NON-CUSTODIAL PARENT _____

PRIMARY INSURANCE COMPANY: _____PHONE:_____

ADDRESS:_____

POLICY No._____ GROUP No. _____ H.M.O. or TRADITIONAL

POLICY COVERAGE: VISION_____ HOSPITAL_____ DOCTOR _____ DENTIST _____ DRUGS _____

CLAIMS ADDRESS IF DIFFERENT: _____

PHONE: _____ _____

OTHER PARTY ORDERED TO MAINTAIN MEDICAL INSURANCE CO.? YES or NO

INSURANCE COMPANY: _____

ADDRESS: _____

POLICY No: _____ GROUP No._____ H.M.O or TRADITIONAL

POLICY COVERAGE: VISION _____ HOSPITAL _____ DOCTOR _____ DENTIST _____ DRUGS _____

CLAIMS ADDRESS IF DIFFERENT: _____

PHONE No. _____ _____