
On List

DEFENDANT'S INTERVIEW FORM

**Court
Room
_____**

PACSES Number(s): _____ Date: _____

Defendant's NAME _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone : (_____) _____ Social Security: _____ - _____ - _____

CURRENT Employer (If unemployed, FORMER Employer): _____

Full Address: _____

Telephone Number: _____ Contact Person: _____

Earnings: Gross or net \$: _____ how often are you paid? (Circle one) Daily, Weekly, Bi-weekly, semi-monthly, monthly

Do you have a law suit pending? (Check all that apply) Worker's Comp SSD Personal Injury Inheritance

Name, address and phone number of attorney representing you: _____

If you are unemployed, are you receiving: (check ALL which apply?)

	Dates:	Amount per month
<input type="checkbox"/> Cash for odd jobs/occasional	_____	_____
<input type="checkbox"/> Unemployment Compensation:	_____	_____
<input type="checkbox"/> Workman's Compensation:	_____	_____
<input type="checkbox"/> Pension	_____	_____
<input type="checkbox"/> S.S.I. <input type="checkbox"/> S.S.D	_____	_____
<input type="checkbox"/> Disability _____ (Ins.Co)	_____	_____
<input type="checkbox"/> V.A. Benefits:	_____	_____
<input type="checkbox"/> Cash Assistance (Welfare)	_____	_____
<input type="checkbox"/> Income / Support from other source	_____	_____

Who provides the child, children or spouse's health insurance? _____

Name of Your Insurance Co: _____

Policy Number: _____ Group Number: _____ Date Coverage Begins and Ends: _____

Type of Insurance: (Circle one) Medicare, HMO, Hospital only, Major Medical. CO-PAY: _____

Is Insurance through your employer: YES NO? Costs: _____

When is it paid: (Circle one) monthly, quarterly, semi-annually, yearly

I verify that this is true and complete, subject to the penalties of 18 Pa CSA section 4904 relating unsworn falsification to authorities.

Date: _____ Signature: _____