
On List

PLAINTIFF'S INTERVIEW FORM

Court Room # _____

PACSES number: _____ Date: _____

Name: _____ Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Social Security: _____ - _____ - _____

Check if Deft's Child's First Name DOB and Age Do you incur any of the following expenses: How much does it cost?

- | | | | | | | | | | | | |
|--------------------------|-------|-------|--------------------------|---------|--------------------------|------|--------------------------|---------|--------------------------|----------------|-------|
| <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | daycare | <input type="checkbox"/> | camp | <input type="checkbox"/> | lessons | <input type="checkbox"/> | private school | _____ |
| <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | daycare | <input type="checkbox"/> | camp | <input type="checkbox"/> | lessons | <input type="checkbox"/> | private school | _____ |
| <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | daycare | <input type="checkbox"/> | camp | <input type="checkbox"/> | lessons | <input type="checkbox"/> | private school | _____ |
| <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | daycare | <input type="checkbox"/> | camp | <input type="checkbox"/> | lessons | <input type="checkbox"/> | private school | _____ |
| <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | daycare | <input type="checkbox"/> | camp | <input type="checkbox"/> | lessons | <input type="checkbox"/> | private school | _____ |

Are you receiving: CASH ASSISTANCE FOOD STAMPS MEDICAL SSI SSD Child care subsidies?

Do the child/ children receive? SSI SSD Durative benefit? Who: _____

CURRENT Employer (If unemployed LAST Employer): _____

Address: _____ Telephone Number: _____

Contact Person: _____ Earnings\$ _____ Gross/Net (Circle one) weekly, bi-weekly, semi-monthly, and monthly

Name of Insurance Co: _____ Who is covered _____

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

Type of Insurance (Circle one) Medicare, HMO, Hospital only, and Major Medical

Is Insurance through employer: YES NO Costs \$ _____

When is it paid: (Circle one) Monthly, Quarterly, Semi-annually, or Yearly?

Do you have recurring medical expenses for your child/ren? YES NO

Are you married to the deft? YES NO Date of Marriage: _____ Separation date: _____

If married, do you own a home with the deft? YES NO If yes, monthly mortgage amount: _____

If you do not reside with the defendant, do you know his/her addressor employer? _____

Street Address: _____ CITY _____ STATE _____ ZIP _____

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: _____