

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

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

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**

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

EFFECTIVE DATE: _____ TOTAL AMOUNT OF ORDER: \$ _____

CHILD SUPPORT AMOUNT: _____ SPOUSAL SUPPORT AMOUNT: _____

ARREARAGE AMOUNT: _____ ORDERED AMOUNT ON ARREARS: _____

FREQUENCY OF WAGES: _____ JUDGE ASSIGNED: _____

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

CUSTODIAL PARENT'S ATTORNEY: _____ PHONE: _____

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. _____