

**BUTLER COUNTY COMMON PLEAS COURT
DIVISION OF DOMESTIC RELATIONS**

WITHHOLDING ORDER/QUALIFIED MEDICAL CHILD SUPPORT ORDER INFORMATION SHEET

DATE: _____ REQUESTED BY: _____ CASE NO. _____

OBLIGOR (PERSON ORDERED TO PAY): _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

PHONE: _____ PAYROLL ADDRESS: _____

NAME AND ADDRESS OF EMPLOYER: _____

EMPLOYER PHONE: _____

PAY SCHEDULE: G Weekly G Bi-weekly G Semi-monthly G Monthly

MONTHLY OBLIGATION \$ _____ OBLIGATION PER PAY PERIOD \$ _____ -- _____

FINANCIAL INSTITUTIONS

NAME AND ADDRESS	TYPE OF ACCOUNT	ACCOUNT NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

OBLIGEE (PERSON/AGENCY TO RECEIVE PAYMENTS): _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

PHONE: _____

CASE TYPE: G IV-D Non-ADC G IV-D ADC G Non-IV-D

Number of minor children for whom support is paid (Alternate Recipients covered by insurance) _____

CHILD'S NAME: _____ SOC. SEC. NO: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

RESIDENTIAL PARENT/LEGAL GUARDIAN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CHILD'S NAME: _____ SOC. SEC. NO: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

RESIDENTIAL PARENT/LEGAL GUARDIAN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CHILD'S NAME: _____ SOC. SEC. NO: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

RESIDENTIAL PARENT/LEGAL GUARDIAN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PARTICIPANT (PERSON ORDERED TO PROVIDE INSURANCE):

PROVIDER OF INSURANCE IS: Obligor Obligor's Spouse _____ Other _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE: _____

INSURANCE IS UNDER: GROUP PLAN PRIVATE PLAN

NAME(S) OF PLAN(S): _____

NAME(S) / ADDRESS(ES) OF PLAN ADMINISTRATOR(S): _____

POLICY AND/OR GROUP NUMBER(S): _____

DESCRIPTION OF TYPE OF COVERAGE TO BE PROVIDED: _____

PARTICIPANT (PERSON ORDERED TO PROVIDE INSURANCE): _____

PROVIDER OF INSURANCE IS: Obligee Obligee's Spouse _____ Other _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE: _____

INSURANCE IS UNDER: GROUP PLAN PRIVATE PLAN

NAME(S) OF PLAN(S): _____

NAME(S) / ADDRESS(ES) OF PLAN ADMINISTRATOR(S): _____

POLICY AND/OR GROUP NUMBER(S): _____

DESCRIPTION OF TYPE OF COVERAGE TO BE PROVIDED: _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM. FORM MAY NOT BE ACCEPTED IF NOT COMPLETED IN FULL AND LEGIBLY TYPED OR WRITTEN.

A COPY OF ALL AVAILABLE INSURANCE CARDS SHALL BE ATTACHED.