

BACKGROUND FOR APL PETITION

Name of Petitioner \_\_\_\_\_ Social Security Number \_\_\_\_\_
Address \_\_\_\_\_
Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_ Phone # \_\_\_\_\_
Maiden name of Petitioner \_\_\_\_\_ Name of Attorney \_\_\_\_\_
Name and Address of employer \_\_\_\_\_
Occupation \_\_\_\_\_ Average weekly net income \_\_\_\_\_

Name of Respondent \_\_\_\_\_ Social Security Number \_\_\_\_\_
Address \_\_\_\_\_
Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_ Phone # \_\_\_\_\_
Name and Address of employer \_\_\_\_\_
Occupation \_\_\_\_\_ Average weekly net income \_\_\_\_\_

Respondent's military service \_\_\_\_\_ Respondent's Atty. \_\_\_\_\_
Race \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Color hair \_\_\_\_\_ Eyes \_\_\_\_\_
Respondent's Father's name and address \_\_\_\_\_
Respondent's Mother's name and address \_\_\_\_\_
Other income(s) for parties (if applicable) \_\_\_\_\_

When and Where married \_\_\_\_\_ Date of separation \_\_\_\_\_
Last marital domicile \_\_\_\_\_
Are you Plaintiff or Defendant in the underlying divorce action? \_\_\_\_\_
Prothonotary's Docket No. \_\_\_\_\_
When and how much was the Respondent's last contribution for APL/Spousal support? \_\_\_\_\_

Are you receiving Public Assistance?( ) Yes ( ) No; Dept. of Public Welfare # \_\_\_\_\_
Did you ever file a complaint for support or APL in any court? ( ) Yes ( ) No
If so, Where? \_\_\_\_\_ What is the status of that case? \_\_\_\_\_

Reason for separation \_\_\_\_\_
Remarks \_\_\_\_\_

Are you requesting medical support services? \_\_\_\_\_
Medical Insurance Information: Complete this section as fully as possible at the time of application.

Who insures the Petitioner for whom APL is requested?
\_\_\_\_\_ Respondent \_\_\_\_\_ Petitioner

Respondent's Insurance Information
Insurance Carrier: \_\_\_\_\_

Petitioner's Insurance Information
Insurance Carrier: \_\_\_\_\_

Group/Policy/Agreement number: \_\_\_\_\_

Group/Policy/Agreement number: \_\_\_\_\_

List of names for those covered: \_\_\_\_\_

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- Type of Coverage:
( ) Medicare Part A
( ) Medicare Part B
( ) Dental coverage
( ) Vision coverage
( ) Major Medical coverage
( ) Hospital Plan only
( ) Basic Hospitalization/Physician
( ) Drug/Prescription coverage/Plan
( ) NO COVERAGE AVAILABLE AT PRESENT

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Date \_\_\_\_\_ Petitioner/Attorney Signature \_\_\_\_\_

-----Domestic Relations Office Use Below This Line-----
Date APL request received by DRS \_\_\_\_\_ DRO number \_\_\_\_\_
Docket number \_\_\_\_\_

Conference Information \_\_\_\_\_
DATE MEDICAL INFORMATION IS FULLY COMPLETED AND VERIFIED
H.O./DRO worker inserting completion date \_\_\_\_\_ Date PC Data \_\_\_\_\_