

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: _____

List of names for those covered: _____

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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() Medicare Part A
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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 _____