

In the Court of Common Pleas of

County, Pennsylvania

Phone:

Fax:

) Docket Number
Plaintiff)
vs.) PACSES Case Number
)
Defendant) Other State ID Number

Please note: All correspondence must include the PACSES Case Number.

Income Statement

THIS FORM MUST BE FILLED OUT AND YOU MUST PROVIDE DOCUMENTS TO SUPPORT ALL AMOUNTS PROVIDED IN THIS INCOME STATEMENT

(If you are self-employed or if you are salaried by a business of which you are owner in whole or in part, you must also fill out the Supplemental Income Statement which appears below.)

INCOME STATEMENT OF

_____	_____
(Name)	(Pacses Number)

I verify that the statements made in this Income Statement are true and correct. I understand that false statements herein are made subject to the penalties of 18 Pa. C.S.A. § 4904 relating to unsworn falsification to authorities.

Date: _____

Plaintiff or Defendant

INCOME

Employer: _____

Address: _____

Type of Work: _____

Payroll Number: _____

Pay Period (weekly, biweekly, etc): _____

Gross Pay per Pay Period \$ _____

Itemized Payroll Deductions: _____

Federal Withholding \$ _____

FICA _____

Local Wage Tax _____

State Income Tax _____

Mandatory Retirement _____

Union Dues _____

Health Insurance _____

Other (specify) _____

_____	_____
_____	_____
Net Pay per Pay Period:	\$ _____

Income Statement (Continued)

PACSES Case Number

Other Income:

	Week	Month	Year
	(Fill in Appropriate Column)		
Interest	\$ _____	\$ _____	\$ _____
Dividends	_____	_____	_____
Pension Distributions	_____	_____	_____
Annuity	_____	_____	_____
Social Security	_____	_____	_____
Rents	_____	_____	_____
Royalties	_____	_____	_____
Unemployment Comp.	_____	_____	_____
Workers Comp.	_____	_____	_____
Employer Fringe Benefits	_____	_____	_____
Other	_____	_____	_____
		\$ _____	\$ _____
TOTAL INCOME		\$ _____	

PROPERTY OWNED

Description	Value	Ownership*		
		H	W	J
Checking accounts	\$ _____	_____	_____	_____
Savings accounts	_____	_____	_____	_____
Credit Union	_____	_____	_____	_____
Stocks/bonds	_____	_____	_____	_____
Real Estate	_____	_____	_____	_____
Other	_____	_____	_____	_____
Total	\$ _____			

INSURANCE

Company	Policy No.	Coverage*		
		H	W	C
Hospital				
Blue Cross	_____	_____	_____	_____
Other	_____	_____	_____	_____
Medical				
Blue Shield	_____	_____	_____	_____
Other	_____	_____	_____	_____
Health/Accident	_____	_____	_____	_____
Disability Income	_____	_____	_____	_____
Dental	_____	_____	_____	_____
Other	_____	_____	_____	_____

*H=Husband; W=Wife; J=Joint; C=Child

SUPPLEMENTAL INCOME STATEMENT (You only need to complete the below portion if you are self-employed or if you are salaried by a business of which you are owner in whole or in part)

(a) This form is to be filled out by a person (check one):

- (1) who operates a business or practices a profession, or
- (2) who is a member of a partnership or joint venture, or
- (3) who is a shareholder in and is salaried by a closed corporation or similar entity.

(b) Attach to this statement a copy of the following documents relating to the partnership, joint venture, business, profession, corporation or similar entity:

- (1) the most recent Federal Income Tax Return, and
- (2) the most recent Profit and Loss Statement.

(c) Name of business: _____

Address and telephone number: _____

(d) Nature of business

(check one)

- (1) partnership
- (2) joint venture
- (3) profession
- (4) closed corporation
- (5) other

(f) Annual income from business: _____

(1) How often is income received? _____

(2) Gross income per pay period: _____

(3) Net income per pay period: _____

(4) Specific deductions, if any: _____