

In the Court of Common Pleas of LEBANON County, Pennsylvania

DOMESTIC RELATIONS SECTION - CIVIL

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

APPLICATION FOR ASSIGNMENT OF COUNSEL

I, _____, hereby apply for the assignment of counsel to represent me in the above-captioned Domestic Relations case.

1. My address is: _____

2. My telephone number is: _____

3. My Social Security Number is: _____

4. My date of birth is: _____

5. The reason I am seeking counsel is: _____

Hearing/Conference Date/Time: _____

Other Reason: _____

6. I am the parent of the following child(ren) who live(s) with me:

(Give names and ages)

a. _____

b. _____

c. _____



7. I provide support for the following persons who do not live in my home (Give names and ages):

a. _____

b. _____

c. _____

8. The following persons also reside in my home, (Give names and ages) and their incomes are as follows:

a. _____

b. _____

c. _____

9. I do or do not (circle one) provide for my own living expenses. If you do not provide for your own living expenses, explain who provides your support and how much:

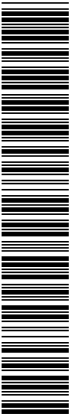
10. I did or did not (circle one) talk to a private lawyer about my case. If you did, state the lawyer's name and why he/she is not handling your case:

11. Complete the attached financial statement providing full, accurate information.

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

Date

Signature



In the Court of Common Pleas of LEBANON County, Pennsylvania

DOMESTIC RELATIONS SECTION

MUNICIPAL BLDG, ROOM 202, 400 SOUTH 8TH STREET, LEBANON PA 17042

Phone: (717) 228-4480

Fax: (717) 274-8358

vs.	Plaintiff) Docket Number:
)
) 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) _____

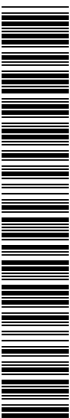
Net Pay per Pay Period: \$ _____

Form IN-008 07/15

Worker ID



Service Type



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

(e) Name of accountant, controller or other person in charge of financial records:

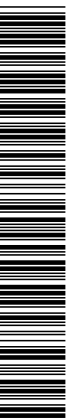
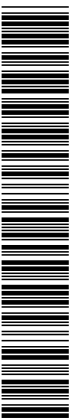
(f) Annual income from business: _____

(1) How often is income received? _____

(2) Gross income per pay period: _____

(3) Net income per pay period: _____

(4) Specific deductions, if any: _____



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Phone: (717) 228-4480

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

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

Guidelines Expense Statement

EXPENSE STATEMENT OF

(Name)	(Pacses Number)
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I verify that the statements made in this Expense 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

Instructions: Guidelines Expense Statement - This form should only be completed when:

- 1) You are requesting an adjustment to the amount of support pursuant to Rule 1910.16-5 because of unusual needs and unusual fixed obligations, other support obligations, medical expenses not covered by insurance, or any other relevant factors, or
- 2) You are requesting that the other party share in the following expenses pursuant to Rule 1910.16-6: child care expenses, health insurance premiums, unreimbursed medical expenses, private school tuition, summer camp, or other needs, or mortgage payment.

You must provide documents to support all amounts provided in this Expense Statement

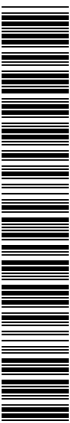
	Weekly	Monthly	Yearly
	(Fill in Appropriate Column)		
Mortgage (including real estate taxes and homeowner's insurance) or Rent	\$	\$	\$
Health Insurance Premiums			
Unreimbursed Medical Expenses:			
Doctor			
Dentist			
Orthodontist			
Hospital			
Medicine			
Special Needs (glasses, braces, orthopedic devices, therapy)			

Form IN-008 07/15

Worker ID



Service Type



Guidelines Expense Statement (Continued)

PACSES Case Number:

	Weekly	Monthly	Yearly
Child Care			
Private School			
Parochial school			
Loans/Debts			
Support of Other Dependents:			
Other child support			
Alimony payments			
Other: (Specify)			
Total	\$	\$	\$

