DR Form 201
Eff. 1/1/2015

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: G Obligor G Obligor's Spouse _____ G Other _____

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

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

_____

EMPLOYER PHONE: _____

INSURANCE IS UNDER: G GROUP PLAN G 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: G Obligee G Obligee's Spouse _____ G Other _____

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

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

_____

EMPLOYER PHONE: _____

INSURANCE IS UNDER: G GROUP PLAN G 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.