BUTLER COUNTY COMMON PLEAS COURT DIVISION OF DOMESTIC RELATIONS

WITHHOLDING ORDER/QUALIFIED MEDICAL CHILD SUPPORT ORDER INFORMATION SHEET

DATE: REQUESTED BY	Y:	CASE NO	
OBLIGOR (PERSON ORDERED TO PAY):		
ADDRESS:	CITY:	STATE:	ZIP:
SOCIAL SECURITY NUMBER:			
PHONE:		PAYROLL ADDRES	S:
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	\$	
		ATC!	
NAME AND ADDRESS	FINANCIAL INSTITUTION		LAHA (DED
NAME AND ADDRESS	TYPE OF ACCOUNT	ACCOUNT	NUMBER
OBLIGEE (PERSON/AGENCY TO RECE	IVE PAYMENTS):		
ADDRESS:			
SOCIAL SECURITY NUMBER:			
PHONE:		_ DATE OF BIRTH	
CASE TYPE: G IV-D Non-ADC		DC	G Non-IV-D
CASE TITE. GIV-D Noil-ADC	GIV-DA	DC	G Noll-1 V-D
Number of minor children for whom support	is paid (Alternate Recipients covered	d by insurance)	
CHILD'S NAME:	SOC SEC NO:	DATE OF R	IRTH.
ADDRESS:			
RESIDENTIAL PARENT/LEGAL GUARD ADDRESS:			
ADDRESS:	CII I:	STATE:	ZIP:
CHILLDIC MANNE.	SOC SEC NO.	DATE OF D	IDTH.
CHILD'S NAME:			
ADDRESS:			
RESIDENTIAL PARENT/LEGAL GUARD			
ADDRESS:	CITY:	STATE:	ZIP:
CHILD'S NAME:			
ADDRESS:	CITY:	STATE:	ZIP:
RESIDENTIAL PARENT/LEGAL GUARD	IAN:		
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):		
PARTICIPANT (PERSON ORDERED TO PROVIDE INSURANCE): PROVIDER OF INSURANCE IS: G Obligee G Obligee's Spouse	G Other	
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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.