Print

In the Court of Common Pleas of County, Pennsylvania

Phone: **Fax:**

Plaintiff	)	Docket Number
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

(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: $ __________

Service Type

Form IN-008 Rev. 1

Worker ID

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

(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: ______________________________

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

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	)	
Defendant	)	Other State ID Number

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Guidelines Expense Statement

EXPENSE STATEMENT OF

(Name) (Pacses Number)

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 the combined monthly net income of the parties is $20,000 or less and:

1) The party is claiming unusual needs and expenses that may warrant deviation from the support guidelines pursuant to Rule 1910.16-5, or
2) The party seeks an apportionment of expenses pursuant to Rule 1910.16-5.

At the conference you must provide receipts or other verification of expenses claimed on this statement.

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

Service Type

Form IN-008 Rev. 1
Worker ID