_____

v.

_____

No.

_____

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:	**$** _____

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	**$** _____	**$** _____	**$** _____

TOTAL INCOME **$** _____

PROPERTY OWNED

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

INSURANCE

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

*** H** 5 **Husband; W** 5 **Wife; J** 5 **Joint; C** 5 **Child**

SUPPLEMENTAL INCOME STATEMENT

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

u **(1) who operates a business or practices a profession, or**

u **(2) who is a member of a partnership or joint venture, or**

u **(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)

u **(1) partnership**

u **(2) joint venture**

u **(3) profession**

u **(4) closed corporation**

u **(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)

Specified deductions, if any: _____

(2) *Expense Statements*. An Expense Statement is not required in cases that can be determined pursuant to the guidelines unless a party avers unusual needs and expenses that may warrant a deviation from the guideline amount of support pursuant to Pa.R.C.P. No. 1910.16-5 or seeks an apportionment of expenses pursuant to Pa.R.C.P. No. 1910.16-6. See Pa.R.C.P. No. 1910.11(c)(1). Child support is calculated under the guidelines based upon the monthly net incomes of the parties, with additional amounts ordered as necessary to provide for child care expenses, health insurance premiums, unreimbursed medical expenses, mortgage payments, and other needs, contingent upon the obligor's ability to pay. The Expense Statement in subparagraph (A) shall be utilized if a party is claiming that he or she has unusual needs and unusual fixed expenses that may warrant deviation or adjustment in a case determined under the guidelines. In child support, spousal support, and alimony *pendente lite* cases calculated pursuant to Pa.R.C.P. No. 1910.16-3.1 and in divorce cases involving claims for alimony, counsel fees, or costs and expenses pursuant to Pa.R.C.P. No. 1920.31(a), the parties shall complete the Expense Statement in subparagraph (B).

Note: *See* Pa.R.C.P. No. 1930.1(b). To the extent this rule applies to actions not governed by other legal authority regarding confidentiality of information and documents in support actions or that attorneys or unrepresented parties file support-related confidential information and documents in non-support actions (e.g., divorce, custody), the *Case Records Public Access Policy of the Unified Judicial System of Pennsylvania* shall apply.

(A) Guidelines Expense Statement. If the combined monthly net income of the parties is $30,000 or less, it is not necessary to complete this form unless a party is claiming unusual needs and expenses that may warrant a deviation from the guideline amount of support pursuant to Rule 1910.16-5 or seeks an apportionment of expenses pursuant to Rule 1910.16-6. At the conference, each party must provide receipts or other verification of

expenses claimed on this statement. The Guidelines Expense Statement shall be substantially in the following form.

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

	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)	_____	_____	_____
Child Care	_____	_____	_____
Private school	_____	_____	_____
Parochial school	_____	_____	_____
Loans/Debts	_____	_____	_____
Support of Other Dependents:			
Other child support	_____	_____	_____
Alimony payments	_____	_____	_____
Other:(Specify)	_____	_____	_____
Total	$ _____	$ _____	$ _____

(B) Expense Statement for Cases Pursuant to Rule 1910.16-3.1 and Rule 1920.31. No later than five business days prior to the conference, the parties shall exchange this form, along with receipts or other verification of the expenses set forth on this form. Failure to comply with this provision may result in an appropriate order for sanctions and/or the entry of an interim order based upon the information provided.

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

	Monthly	**Monthly**	**Monthly**

EXPENSES	Total	Children	Parent
HOME			
Mortgage or Rent	_____	_____	_____
Maintenance	_____	_____	_____
Lawn Care	_____	_____	_____
2nd Mortgage	_____	_____	_____
UTILITIES			
Electric	_____	_____	_____
Gas	_____	_____	_____
Oil	_____	_____	_____
Telephone	_____	_____	_____
Cell Phone	_____	_____	_____
Water	_____	_____	_____
Sewer	_____	_____	_____
Cable TV	_____	_____	_____
Internet	_____	_____	_____
Trash/Recycling	_____	_____	_____
TAXES			
Real Estate	_____	_____	_____
Personal Property	_____	_____	_____
INSURANCE			
Homeowners/Renters	_____	_____	_____
Automobile	_____	_____	_____
Life	_____	_____	_____
Accident/Disability	_____	_____	_____
Excess Coverage	_____	_____	_____
Long-Term Care	_____	_____	_____
AUTOMOBILE			
Lease or Loan Payments	_____	_____	_____
Fuel	_____	_____	_____
Repairs	_____	_____	_____
Memberships	_____	_____	_____
MEDICAL			
Medical Insurance	_____	_____	_____
Doctor	_____	_____	_____
Dentist	_____	_____	_____
Hospital	_____	_____	_____
Medication	_____	_____	_____
Counseling/Therapy	_____	_____	_____
Orthodontist	_____	_____	_____
Special Needs (glasses, etc.)	_____	_____	_____
EDUCATION			
Tuition	_____	_____	_____

Tutoring	_____	_____	_____
Lessons	_____	_____	_____
Other	_____	_____	_____
PERSONAL			
Debt Service	_____	_____	_____
Clothing	_____	_____	_____
Groceries	_____	_____	_____
Haircare	_____	_____	_____
Memberships	_____	_____	_____
MISCELLANEOUS			
Child Care	_____	_____	_____
Household Help	_____	_____	_____
Summer Camp	_____	_____	_____
Papers/Books/Magazines	_____	_____	_____
Entertainment	_____	_____	_____
Pet Expenses	_____	_____	_____
Vacations	_____	_____	_____
Gifts	_____	_____	_____
Legal Fees/Prof. Fees	_____	_____	_____
Charitable contributions	_____	_____	_____
Children's Parties	_____	_____	_____
Children's Allowances	_____	_____	_____
Other Child Support	_____	_____	_____
Alimony payments	_____	_____	_____
TOTAL MONTHLY EXPENSES			
	_____	_____	_____