PACSES #: _____

CLARION COUNTY DRS AGREEMENT FORM

Plaintiff Name: _____
Address: _____
_____
Phone #: _____
Employer Name: _____
Employer phone #: _____

Defendant Name: _____
Address: _____
_____
Phone #: _____
Employer Name: _____
Employer phone #: _____

I agree to the following support order:
MONTHLY AMOUNT

$_____per month, EFFECTIVE _____.
(date)

Support shall be allocated in the following manner:
Child Monthly Amount: _____
Spousal Monthly Amount: _____

INSURANCE INFORMATION

The insurance is currently carried by: _____ PLAINTIFF _____ DEFENDANT

The insurance is through (circle): Welfare Affordable Care Act Employer Military

If the insurance is through Welfare or the Affordable Care Act, both parties will be ordered to provide insurance if it's available at a reasonable cost.

Unreimbursed Medical: _____% PLAINTIFF _____% DEFENDANT

You must attach a copy of the insurance card(s) to this agreement for it to be valid.

Please complete all information on both sides.

INCOME INFORMATION

Title 23 of the PA Consolidated statutes requires a guideline amount of support to be established. Please provide the following income information for both parties:

Plaintiff: $_____ (weekly, biweekly, monthly) gross income.
(circle one)

Defendant: $_____ (weekly, biweekly, monthly) gross income.
(circle one)

NOTE: BY SIGNING THE ABOVE IT'S UNDERSTOOD THAT YOU AGREE TO THE CURRENT SUPPORT OBLIGATION AND THAT THIS SUPPORT OBLIGATION MAY NOT BE MODIFIED OR REVIEWED UNLESS THERE IS WRITTEN CONSENT FROM BOTH PARTIES, A SIGNIFICANT CHANGE IN CIRCUMSTANCE, OR IT HAS BEEN AT LEAST 3 YEARS. YOU ALSO AGREE TO THE AMOUNT WITHOUT A CONFERENCE. DRS WILL COMPLETE A GUIDELINE CALCULATION OF THIS CASE BASED ON THE INCOMES PROVIDED ABOVE. YOU ARE ABLE TO VERIFY AN ESTIMATED GUIDELINE SUPPORT AMOUNT BY USING THE SUPPORT ESTIMATOR ON THE CHILD SUPPORT WEBSITE (www.childsupport.state.pa.us).

_____	_____	_____
DATE	PLAINTIFF SIGNATURE	PHONE #

_____	_____	_____
DATE	DEFENDANT SIGNATURE	PHONE #

DRS Personnel accepting agreement: _____