

**IN THE COURT OF COMMON PLEAS
DOMESTIC RELATIONS DIVISION
BUTLER COUNTY, OHIO**

**WITHHOLDING ORDER/QUALIFIED MEDICAL CHILD SUPPORT ORDER
INFORMATION SHEET**

Note: 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.

Date: _____

Requested By _____ Case No. _____

OBLIGOR (Person Ordered To Pay):

Name

Date of Birth – i.e. (11/05/2022)

Address

SSN – i.e. (111-22-3333)

City, State and Zip Code

Email – i.e. (Username@Gmail.Com)

Telephone No. – i.e. (111) 222 – 3333

Employer Information

Payroll Information

Business Name

Business Name

Address

Address

City, State and Zip Code

City, State and Zip Code

Telephone No. – i.e. (111) 222 – 3333

Telephone No. – i.e. (111) 222 – 3333

Email – i.e. (Username@Gmail.Com)

Email – i.e. (Username@Gmail.Com)

DR 201
Eff. 1/1/2015

PAY SCHEDULE: Weekly Bi-weekly Semi-monthly Monthly
MONTHLY OBLIGATION \$ _____ OBLIGATION PER PAY PERIOD \$ _____ - _____

FINANCIAL INSTITUTIONS

_____		_____	
Institution Name		Institution Name	
_____		_____	
Address		Address	
_____		_____	
City, State and Zip Code		City, State and Zip Code	
_____		_____	
Telephone No. – i.e. (111) 222 – 3333		Telephone No. – i.e. (111) 222 – 3333	
_____	_____	_____	_____
Type of Account	Account Number	Type of Account	Account Number

_____		_____	
Institution Name		Institution Name	
_____		_____	
Address		Address	
_____		_____	
City, State and Zip Code		City, State and Zip Code	
_____		_____	
Telephone No. – i.e. (111) 222 – 3333		Telephone No. – i.e. (111) 222 – 3333	
_____	_____	_____	_____
Type of Account	Account Number	Type of Account	Account Number

OBLIGEE (Person/Agency To Recive Payment):

_____ Name	_____ Date of Birth – i.e. (11/05/2022)
_____ Address	_____ SSN – i.e. (111-22-3333)
_____ City, State and Zip Code	_____ Email – i.e. (Username@Gmail.Com)
_____ Telephone No. – i.e. (111) 222 – 3333	

CASE TYPE: IV-D Non-ADC IV-D ADC Non-IV-D

Number of minor children for whom support is paid (Alternate Recipients covered by insurance)

CHILD(REN) INFORMATION & ADDRESS

**RESIDENTIAL PARENT/LEGAL
GUARDIAN**

_____ Child's Name	_____ Parent/Legal Guardian Name
_____ SSN – i.e. (111-22-3333)	_____ Date of Birth – i.e. (11/05/2022)
_____ Address	_____ Address
_____ City, State and Zip Code	_____ City, State and Zip Code

_____ Child's Name	_____ Parent/Legal Guardian Name
_____ SSN – i.e. (111-22-3333)	_____ Date of Birth – i.e. (11/05/2022)
_____ Address	_____ Address
_____ City, State and Zip Code	_____ City, State and Zip Code

_____ Child's Name	_____ Parent/Legal Guardian Name
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SSN – i.e. (111-22-3333) Date of Birth – i.e. (11/05/2022)

Address

City, State and Zip Code

PARTICIPANT/OBLIGOR
(Person Ordered To Provide Insurance)

Name

Provider of Insurance Is:

Obligor

Obligor's Spouse _____

Other _____

Address

City, State and Zip Code

SSN – i.e. (111-22-3333)

Date of Birth – i.e. (11/0)

Description of Type of Coverage To Be Provided:

Address

City, State and Zip Code

EMPLOYER INFORMATION

Name

Address

City, State and Zip Code

Insurance Under: Group Plan Private Plan

Name(s) of Plan(s)

Name(s) of Plan Administrator(s)

Address

City, State and Zip Code

Policy And/Or Group Number

Max 1,000 Characters - if more space is needed, a signed and notarized statement can be attached (Ref. Obligor Coverage)

PARTICIPANT/OBLIGEE
(Person Ordered To Provide Insurance)

Name

Provider of Insurance Is:

Obligee _____

Obligee's Spouse _____

Other _____

Address

City State Zip

SSN – i.e. (111-22-3333)

Date of Birth – i.e. (01/31/2020)

Description of Type of Coverage To Be Provided:

EMPLOYER INFORMATION

Name

Address

City, State and Zip Code

Insurance Under: Group Plan Private Plan

Name(s) of Plan(s)

Name(s) of Plan Administrator(s)

Address

City, State and Zip Code

Policy And/Or Group Number

Max 1,000 Characters - if more space is needed, a signed and notarized statement can be attached (Ref. Obligee Coverage)