LAW OFFICE OF KAYE M. ALDERMAN

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INITIAL CONSULTATION INFORMATION

Name: _____

Date/Time of Appointment: _____

Referred by: _____

Personal Information

Address: _____

_____**Zip**_____

Cell Phone: _____

Home Phone: _____

E-Mail: _____

Date of Birth: _____

Age: _____

Place of Birth: **City:** _____ **County:** _____

Place of Employment: _____

Address of Employment: _____

Telephone of Employment: _____

Monthly Net Income: _____

Type of Case: **( ) Divorce ( ) Child Custody**

( ) Child Support Enforcement or Modification

( ) Other (Please specify) _____

Number of Children: _____

Names and Ages: _____

_____

_____

Facts of Case:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

CASE PARTY DATA SHEET

COUNTY: _____

CLIENT:

Full Name: _____
Maiden Name (if female): _____
Home address: _____
How long at address: _____
Telephone Number: _____
Employer: _____
Address: _____ Tele: _____
Date of Birth: _____ Place of Birth (city):_____
Current age: _____

OTHER PARTY:

Full Name: _____
Maiden Name (if female): _____
Home address: _____
How long at address: _____
Telephone Number: _____
Employer: _____
Address: _____ Tele: _____
Date of Birth: _____ Place of Birth (city):_____
Current age: _____

MARRIAGE: Date of Marriage: _____
(If applicable) Date of Separation: _____
Place of Marriage: _____

CHILDREN: Number of Children: _____

Name: _____Sex:_____
Birth date: _____ Place of Birth (city):_____

Name: _____Sex:_____
Birth date: _____ Place of Birth (city):_____

Name: _____Sex:_____
Birth date: _____ Place of Birth (city):_____

STATEMENT OF HEALTH INSURANCE AVAILABILITY

This statement is made by _____, [petitioner/respondent], in accordance with section 154.181 of the Texas Family Code.

1. Child[ren]

The following child[ren] [is/are] the subject of this suit:

Name: _____

Birth date: _____

Social Security number: _____

2. Health Insurance Availability

Private health insurance is in effect for the child[ren], [name(s)].

_____

Name of insurance company: _____

Policy number: _____

Party responsible for premium: _____

Monthly cost of premium: $_____

The insurance coverage [is/is not] provided through a parent's employment.

Name of insurance company: _____

Policy number: _____

Party responsible for premium: _____

Monthly cost of premium: $_____

The insurance coverage [is/is not] provided through a parent's employment.

Name of insurance company: _____

Policy number: _____

Party responsible for premium: _____

Monthly cost of premium: $_____

The insurance coverage is not provided through a parent's employment.

Private health insurance is not in effect for the child[ren], [name(s)].

_____

The child[ren] [is/is not/are/are not] receiving Medicaid benefits under chapter 32, Human Resources Code.

The child[ren] [is/is not/are/are not] receiving health benefits coverage under a government medical assistance program, government health plan, or the Children's Health Insurance Program under chapter 62 of the Texas Health and Safety Code.

The cost of the premium is $_____

_____, mother of the child[ren], [has/does not have] access to private health insurance at reasonable cost to her. _____, father of the child[ren], [has/does not have] access to private health insurance at reasonable cost to him.

_____ has applied for *[Medicaid benefits for the child[ren]]*[and]*[coverage for the child[ren] under a government medical assistance program, government health plan, or the Children's Health Insurance Program]*. The status of the application is _____.

Date: _____.

_____

[name]