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consult \$ _____

**ENFORCEMENT OF VISITATION / GEOGRAPHIC RESTRICTION
IN DECREE/ORDER
INFORMATION SHEET**

Date of Consultation: _____ Referred by: _____
(today's date)

PETITIONER: (If you are filing a new case you are the Petitioner.)

Full Name: _____ Age: _____

Maiden Name: _____ Social Security# (last 4 digits only) _____

Birthdate: _____ D.L. # (last 4 digits only) _____ State: _____

Place of Birth: _____

Home Address & County: _____

Telephone Numbers: (Work): _____ (Home): _____

Other numbers: (Cell): _____ (Fax): _____

Business Name: _____

Business Address: _____

email Address: _____

Salary/Income: _____

RESPONDENT: (If you are responding to a case that was filed against you, you are the Respondent.)

Full Name: _____ Age: _____

Maiden Name: _____ Social Security# (last 4 digits only) _____

Birthdate: _____ D.L. # (last 4 digits only) _____ State: _____

Place of Birth: _____

Home Address & County: _____

Telephone Numbers: (Work): _____ (Home): _____

Business Address: _____

email Address: _____

Salary/Income: _____

Next of Kin: _____ Phone: _____

CHILDREN FROM THIS MARRIAGE/RELATIONSHIP UNDER 18:

Name	S.S. Number (last 4 digits only)	Sex	Birthdate	Birthplace
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

- _____ Temporary Orders Desired?
- _____ Extraordinary Relief Desired?
- _____ Request Award of Attorney's Fees?
- _____ Waiver or Service?

What are you seeking to enforce? Check all that apply:

- _____ payment of child support (the other party is not currently paying or partially paying)
- _____ payment of arrearage on child support (past payments are overdue)
- _____ payment of health insurance for child(ren)
- _____ payment of dental insurance for child(ren)
- _____ reimbursement for medical expenses Did you submit them to the other party? _____ yes _____ no
- _____ visitation

How is the other party hindering your visitation? _____

Do you have documentation showing the other party is hindering your visitation? _____

_____ Other violations of the court order: (Please list specific dates & attach additional sheets as necessary.)

Who is/are the child(ren) living with now and for what period of time: _____

Have you been to court before in this matter? _____

When and Why? _____

Cause No. (Case No.) and County of case _____

(Please provide the latest order.)

How many attorneys have you had? _____

Have many times have you been married? (Include any marriages annulled) _____

Have you ever been charged or convicted with a misdemeanor? If yes, please explain _____

Have you ever been charged or convicted with a felony? If yes, please explain _____

At what age did you graduate from high school? _____

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IN THE DISTRICT COURT
 _____ JUDICIAL DISTRICT
 _____ COUNTY, TEXAS

FINANCIAL INFORMATION STATEMENT
 (Required in All Financial Hearings)

MONTHLY EXPENSES PRESENT	MONTHLY EXPENSES (cont.) PRESENT
<u>HOUSING</u>	<u>YOUR CHILDREN</u>
House Mortgage/Rent _____	Child Care _____
Utilities _____	School Tuition, Fees _____
(Gas, water, etc.) _____	Lunches _____
Maintenance & Repair _____	Supplies _____
Other _____	Medical Expenses _____
	(not covered by ins) _____
<u>TRANSPORTATION</u>	Drugs _____
Car Payment/Lease _____	Doctors, Dentists _____
Gas, Oil, Maintenance _____	Grooming _____
Parking & Tolls _____	Entertainment _____
	Sports, Lessons, etc. _____
<u>INSURANCE</u>	Other: _____
Auto _____	_____
Life _____	_____
Medical _____	_____
Other _____	_____
	<u>TOTAL EXPENSES</u> _____
<u>GROCERIES</u>	_____
Food & Household Supplies _____	INCOME: (attach current pay stubs)
	[] paid monthly [] paid semi-monthly
<u>YOUR PERSONAL</u>	[] paid weekly [] paid every two weeks
Work Expenses:	_____
Lunches, etc. _____	GROSS INCOME
Dues, Fees, etc. _____	<u>DEDUCTIONS</u> _____
Medical Expenses _____	Withholding Tax _____
(not paid by ins):	FICA _____
Drugs _____	Mandatory Retirement _____
Doctors, Dentists _____	Medical Insurance _____
Clothing _____	Children _____
Cleaning, Laundry _____	Other Family _____
Grooming _____	Life Insurance _____
Entertainment _____	Other _____
Current Child Support _____	
Other: _____	<u>OTHER</u> _____

_____	<u>LIQUID ASSETS</u> _____
<u>CREDIT CARD/DEBTS</u>	_____

<u>Monthly Attorney Fees</u> _____	
	I hereby certify that the answers to the above questions as listed are true and correct.
	_____ Date _____ Signed

CAUSE No. _____

IN THE MATTER OF (INTEREST OF)

AND

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IN THE DISTRICT COURT

OF DALLAS COUNTY, TEXAS

_____ JUDICIAL DISTRICT

HEALTH INSURANCE AVAILABILITY FORM

Attention: This information must be filed with the court BEFORE first hearing.
See TEX FAM CODE § 154.181(b).

NAME OF PARTY: _____

MOVANT

RESPONDENT

PARTY'S ATTORNEY (IF ANY): _____

BESIDE THE NAME OF EACH CHILD, CHECK ALL TYPES OF HEALTH INSURANCE OR HEALTH CARE BENEFITS CURRENTLY COVERING THE CHILD(REN). YOU MAY CHECK MORE THAN ONE SOURCE.

NAME	DOB	SSN (LAST 4 DIGITS)	EMPLOYER PROVIDED					OTHER	NONE
			FATHER'S	MOTHER'S	PRIVATE	CHIP			
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR EACH INSURANCE SOURCE PLEASE LIST THE FOLLOWING INFORMATION:
(ATTACH ADDITIONAL FORMS FOR EACH SOURCE OF BENEFITS)

- A. NAME OF CARRIER _____
- B. GROUP POLICY ID NUMBER _____
- C. POLICYHOLDER NAME & ID NUMBER _____
- D. NAME OF COVERED CHILD _____
- E. COST/MONTH OF COVERAGE [CHILD{REN} ONLY] \$ _____

(To determine coverage cost for child(ren), determine total cost for family coverage and subtract from this amount the cost to insure all covered individuals except the children.)

F. ARE YOU CURRENTLY PAYING THE PREMIUMS FOR LISTED MEDICAL BENEFITS? YES NO

STATE YOUR NET MONTHLY INCOME FROM YOUR FINANCIAL INFORMATION STATEMENT: \$ _____

SIGNATURE OF PARTY COMPLETING FORM

DATE

PRINTED NAME