

CLIENT QUESTIONNAIRE

SAPCR

(Suit Affecting Parent Child Relationship)

Client Name: _____ **Date:** _____

Please fill out this questionnaire and return it as soon as possible. It is important that you answer each question fully.

It is imperative that you be **candid!**

You should answer all questions relevant to your case. If a question does not apply to your particular situation, please indicate by marking "N/A". If the answer to any question requires more space than has been provided on the form, please complete your answer on a separate sheet: refer to the question number to which your answer applies, and attach your answer to this questionnaire.

Your responses to these questions will help organize your case and will save you money on attorney's fees in trying to gather and assemble information after the case is in progress.

Since your answers are being made to an attorney, you are assured of confidentiality and are protected by the attorney-client privilege.

NOTICE OF CONFIDENTIALITY

THE INFORMATION IN THIS DOCUMENT IS SUBJECT OF THE ATTORNEY-CLIENT PRIVILEGE, AS PROVIDED IN THE TEXAS RULES OF CIVIL EVIDENCE.

THE CONTENTS OF THIS DOCUMENT CONSTITUTE ATTORNEY WORK PRODUCT.

THE CONTENTS OF THIS DOCUMENT ARE CONFIDENTIAL AND ARE NOT TO BE DISCLOSED TO THIRD PERSONS OTHER THAN THOSE TO WHOM DISCLOSURE IS MADE IN FURTHERANCE OF THE RENDITION OF PROFESSIONAL LEGAL SERVICES.

Office Location:

9442 Capitol of Texas Hwy. N.
Arboretum Plaza One, Suite 500
Austin, Texas 78759

Mailing Address:

Post Office Box 82455
Austin, Texas 78708-2455
E-Mail: ras-atty-med@swbell.net

Telephone:

Ofc. (512) 733-8259
Fax. (512) 533-0800
Cell (512) 633-8259

PERSONAL

ABOUT YOU:

1. Please give the your **full** name, date and place of birth, and Social Security number.

Full Name: _____

Age: _____ Date of Birth: _____

Place of Birth: City:_____ County:_____ State:_____

Social Security Number:_____

Driver's License State and Number: _____

2. Where are you living now, and what is your phone number?

Address: _____

City: _____ County:_____

State: _____ Zip Code:_____

Home Phone Number:_____

Email Address:_____

How long have you lived in Texas?_____ County?_____

3. At what address do you wish to receive your mail from this office?_____

4. How do you prefer that we contact you?

Address: _____

Home Phone:_____

Cell Phone: _____

Email: _____

5. Who referred you to this office?_____

6. Have you consulted or retained any other attorneys on this matter before coming

into this office? _____

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If so, who and when? _____

7. Please complete the following information concerning your employment.

Employer: _____

Job Title: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

May we call you at work? _____

Gross Annual or Monthly Salary: _____

Length of Employment: _____

Education Level: _____

ABOUT YOUR SPOUSE / EX-SPOUSE:

8. Please give your SPOUSE / EX-SPOUSE's **full** name, date and place of birth, and Social Security number.

Full Name: _____

Age: _____ Date of Birth: _____

Place of Birth: City: _____ County: _____ State: _____

Social Security Number: _____

Diver's License State and Number: _____

9. Where is your spouse / ex-spouse living now, and what is his/her phone number?

Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

Phone Number: _____

10. Please complete the following information concerning your spouse or ex-spouse's employment.

Employer: _____

Office Location:

Mailing Address:

Telephone:

Job Title: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Gross Annual or Monthly Salary: _____

Length of Employment: _____

Education Level: _____

ABOUT DECREE:

11. Please give the date and place and cause number of decree.

Cause Number on Decree: _____

Name and Number of Court: _____

County where Pending: _____

Date Decree was Entered: _____

CHILDREN:

12. Please give the full name, date and place of birth, sex and Social Security number of each child:

Full Name: _____

Sex (M/F): _____ Birth Date: _____ State where born: _____

Social Security Number: _____

Full Name: _____

Sex (M/F): _____ Birth Date: _____ State where born: _____

Social Security Number: _____

Full Name: _____

Sex (M/F): _____ Birth Date: _____ State where born: _____

Social Security Number: _____

13. With whom do the children live (Primary)? _____ and
WHERE do they live? _____

14. Do any of the children have a disability? _____
If so, state for each child the disability and the special needs because of the disability.

15. Is there any property owned by the child(ren)? _____
If so, state for each child a list of property owned and approximate value.

CONSERVATORSHIP (CUSTODY) ISSUES:

16. What is the current conservatorship of the child(ren)? Biological Parents are:
Joint Managing Conservators _____ OR _____ is Sole Managing
Conservator and _____ is Sole Possessory Conservator.

17. Other non-biological parent conservators: Name, address, and contact information

18. What conservatorship status do you want? _____

19. Periods of time and possession:
 What is the current schedule?

 What schedule do you propose?

RIGHTS and DUTIES:

20. What are the current rights and duties under the latest orders? _____

(Attach a copy of the current order with all modifications.)

21. What rights and duties do you propose? _____

(Attach additional sheets if needed.)

CHILD SUPPORT:

- 22. What is the current level of child support per month? _____
- 23. Which parent is obligated to pay? _____
- 24. What level of child support do you propose to be fixed? _____
- 25. Do the children currently have health insurance available? (If so, please provide details)_____

(Attach child support financial information forms.)

HEALTH INSURANCE:

- 26. What is the current health insurance available to the child(ren) and who is it through?

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.

*See attached Health Insurance Availability Statement

PROCESS:

- 27. Which parent will file? _____

Has a proceeding been filed already? _____

If so, who filed, when was the proceeding filed, what county and state was it filed and are there any current settings or deadlines?

Who Filed: _____

Date: _____

County: _____

State: _____

Current Settings/Deadlines: _____

28. Is the proceeding likely to be: Contested _____ OR Uncontested _____
If "contested," then on what points? _____

29. What is the date of any PRIOR ORDER? _____

30. Has there been any history of family violence? _____
If so, please describe dates and incidents. _____

LAWYERS:

31. What are the names of the attorneys representing each party?

Petitioner: _____

Attorney Name: _____

Address: _____

Phone #'s: _____

Fax: _____

Respondent: _____

Attorney Name: _____

Address: _____

Phone #'s: _____

Fax: _____

ADDITIONAL NOTES: _____

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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: _____

Name: _____

Birth date: _____

Social Security number: _____

Name: _____

Birth date: _____

Social Security number: _____

2. Health Insurance Availability

Private health insurance is in effect for the child[ren], _____

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], _____

*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 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 /

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or]_____ [coverage for the child[ren] under Children's Health Insurance Program]. The status of the application is _____.

Date: _____.

Printed name: _____

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