



# Court of Common Pleas of Berks County

Twenty Third Judicial District of Pennsylvania  
Domestic Relations Section  
633 Court Street, 6<sup>th</sup> Floor, Reading, PA 19601-4316  
(610) 478-2900 Fax: (610) 478-6585 or 610-478-6583

Tracy Brown, *Director*  
Laura Schlegel, *Deputy Director*

## Suspension of Support Order Form

\_\_\_\_\_ vs. \_\_\_\_\_  
Plaintiff's Name Defendant's Name

PACSES Case ID: \_\_\_\_\_

### All Fields MUST Be Completed.

1. **Effective Date of Suspension:** \_\_\_\_\_
2. **Reinstatement Date:** \_\_\_\_\_ (*The current charging order will reinstate on this date.*)
3. **Reason for Suspension:**
4. **Arrears Provision (CHOOSE AND COMPLETE #1 OR #2 BELOW):**
  1.  **Checkmark if any arrears owed to the plaintiff are to be paid.**  
Monthly Arrears Payment: \$ \_\_\_\_\_ (*If no amount is written, it will be determined by DRS.*)
  2.  **Checkmark if any arrears owed to the plaintiff are to be canceled.\***  
*\*If cancelling arrears, they will be canceled the date DRS prepares a court order and updates the terms of this agreement. Canceled arrears cannot be reinstated.*
5. **Medical Provision:**  
 Checkmark if the same provisions that exist on the current support order will remain in place during the suspended period.

### (OR COMPLETE FIELDS #1 AND #2 BELOW)

1. **Party Responsible for Medical Insurance:** Defendant Plaintiff Both Parties  
*\*Include a copy of insurance card if not previously provided*
2. **Unreimbursed Medical Split:** Defendant's Share \_\_\_\_\_ % Plaintiff's Share \_\_\_\_\_ %  
*\*The plaintiff is responsible for the first \$250/year per child of unreimbursed medical expenses.*

**IMPORTANT INFORMATION:**

If any arrears are owed to the Department of Human Services, an arrears payment will be determined if one is not included on this form. Any remaining court costs are to be paid at a monthly rate to be determined by the DRS.

**Plaintiff's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Plaintiff's Attorney signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Defendant's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Defendant's Attorney signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**THIS SECTION TO BE COMPLETED BY DRS STAFF ONLY.**

Plaintiff's Verbal Consent: \_\_\_\_\_ Plaintiff's Attorney Verbal Consent: \_\_\_\_\_

Defendant's Verbal Consent: \_\_\_\_\_ Defendant's Attorney Verbal Consent: \_\_\_\_\_

DRS Employee Initials: \_\_\_\_\_ Date: \_\_\_\_\_