

STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY	FRIEND OF THE COURT CASE QUESTIONNAIRE	CASE NO. and JUDGE
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Friend of the court address

Telephone no.

Plaintiff

v

Defendant

Complete this form and sign on page 5.
YOUR GENERAL INFORMATION

1. Your full name				2. Date of birth		3. Place of birth: city and state	
4. Address		City		State		Zip	
5. Home telephone		6. Work telephone					
7. Social security number		8. Driver's license no.		9. Professional license, type and no.		10. Cell phone	
11. E-mail address							
12. Sex ☐ M ☐ F		13. Eye color		14. Hair color		15. Height	
16. Weight		17. Race		18. Scars, tattoos, etc.			
19. Your father's full name				20. Your mother's full maiden name			
21. Children in common with other parent in this case		Birthdate		Gender		SSN	
Current grade level		Anticipated month and year of high school graduation		No. of overnights you have with child annually			
22. Names of other biological/adopted minor children you support		Birthdate		Address			
23. Are you pregnant? ☐ Yes ☐ No		a. When is the child due?		b. Is the other party in this case the biological parent of the expected child? ☐ Yes ☐ No		24. Are you presently married? ☐ Yes ☐ No	

YOUR INCOME, MEDICAL, EDUCATIONAL, AND HEALTH INSURANCE INFORMATION

25. Your occupation				26. Your employer (if unemployed, name of last employer)			
27. Employer's address		City		State		Zip	
28. Date hired							
29. Gross earnings per pay period (earnings before taxes) \$ ☐ weekly ☐ biweekly ☐ bimonthly ☐ monthly				30. Filing status _____ dependents claimed ☐ married ☐ single ☐ head of household			
31. Hourly pay rate (including shift premium and COLA)		32. Total regular hours worked per pay period		33. Average overtime hours for past 12 months			

YOUR INCOME, MEDICAL, EDUCATIONAL, AND HEALTH INSURANCE INFORMATION (continued)

34. Second job		35. Employer	
36. Employer's address	City	State	Zip
37. Date hired		38. Gross earnings per pay period (earnings before taxes) \$ ☐ weekly ☐ biweekly ☐ bimonthly ☐ monthly	
39. Hourly pay rate		40. Average hours worked per pay period since hire date	
41. If unemployed and not receiving unemployment or worker's compensation benefits, or working part-time only, provide the following information:			
Name of last full-time employer		Address of last full-time employer	
Position held at last place of full-time employment		Last day employed full-time	
Length of time employed in last full-time position		Reason for leaving last full-time employment	
Gross earnings per pay period (earnings before taxes) \$ ☐ weekly ☐ biweekly ☐ bimonthly ☐ monthly			
42. List MONTHLY income from all other sources, such as:			
Commissions _____	Unemp. Benefits _____	Nat'l Guard & Res. Drill Pay _____	
Bonuses _____	Strike Pay _____	Armed Services _____	
Profit Sharing _____	SUB Pay _____	Allowance for Rent _____	
Interest _____	Sick Benefits _____	Rental Income _____	
Dividends _____	Workers' Comp. _____	Spousal Support/Alimony _____	
Annuities _____	Soc. Sec. Benefits _____	State Disability Assistance _____	
Pensions/Longevity _____	VA Benefits _____	F I P _____	
Deferred Comp./IRA _____	Disability Insurance _____	Supp. Security Income SSI _____	
Trust Funds _____	GI Benefits _____	Other _____	
43. Do you have any spousal support/alimony orders involving another person not a parent in this case? If so, complete a. b. and c. ☐ No ☐ Yes, as payer ☐ Yes, as recipient			
a. Amount of order (do not include arrearages)	b. Type of order/Case no.		c. City, county, and state
44. Do any of the children listed on item 21 and 22 receive payments from the Social Security Administration? ☐ Yes ☐ No			
Child's Name	Amount (monthly)	Type of benefit (check one) SSI ☐ Dependent benefit ☐	
		Source of dependent benefit (mother, father, stepparent)	
45. Attach your four most recent paycheck stubs, or a statement from your employer(s) of wages and deductions, and year-to-date earnings, and a copy of your last federal and state income tax returns, including all schedules. If self-employed, also attach a copy of your three most recent business tax returns and/or corporation returns.			
46. Do you have any medical conditions/restrictions that affect your ability to work? If yes, please explain medical condition/restriction: ☐ Yes ☐ No			
47. What is your educational background? (Check one) ☐ less than high school ☐ High school graduate ☐ Trade school graduate ☐ Associate's degree ☐ Bachelor's degree ☐ Graduate degree			

YOUR INCOME, MEDICAL, EDUCATIONAL, AND HEALTH INSURANCE INFORMATION (continued)

48. Medical insurance company name, address, telephone no.	Policy/Group number	Beginning date, if known
49. Dental insurance company name, address, telephone no.	Policy/Group number	Beginning date, if known
50. Optical insurance company name, address, telephone no.	Policy/Group number	Beginning date, if known
51. What dependent coverage is available to you without cost? ☐ Medical ☐ Dental ☐ Optical		
52. What dependent coverage is available by payment of an additional premium? (Specify cost per pay period.) ☐ Medical _____ per _____ ☐ Dental _____ per _____ ☐ Optical _____ per _____		
53. Individuals currently covered by your insurance		
Name	Birthdate	Relationship Medical () Dental () Optical ()

YOUR CHILD-CARE INFORMATION

54. Do you have child-care expenses for the minor children in this domestic relations case during any time of the year? ☐ Yes ☐ No If yes, complete the following information.			
Name of child-care provider		Names of children receiving child care	
Number of weeks provided during last calendar year		Estimated number of weeks of child care provided in this calendar year	
Current weekly child-care cost.	Amount of child-care credit received on last year's federal I.R.S. tax return.		
Does a federal or state agency or a public or private entity contribute all or a portion of the cost of child-care services? If yes, please explain.			
55. Check the reason(s) which explain why you need child care and estimate the number of hours child care is received for each.			
<u>Reason</u>	<u>Estimated number of hours per week</u>		
☐ Work related	_____		
☐ Looking for employment	_____		
☐ Enrolled in educational program to improve employment opportunities	_____		
56. If your reason for child care is education related, provide the following information.			
Name of educational institution	Total classroom hours per week	Educational goal	Projected graduation date

ADDITIONAL INFORMATION

57. List any additional information about you or the other parent that would be useful to the court in making a support recommendation. For example: education, disability, or work history.

INFORMATION REGARDING THE OTHER PARENT IN THIS CASE (if known)

58. Full name				59. Date of birth		60. Place of birth: city and state	
61. Address		City		State		Zip	
62. Home telephone		63. Work telephone					
64. Social security number		65. Driver's license no.		66. Professional license, type and no.		67. Cell phone	
68. E-mail address							
69. Sex ☐ M ☐ F		70. Eye color		71. Hair color		72. Height	
73. Weight		74. Race		75. Scars, tattoos, etc.			
76. Father's full name				77. Mother's full maiden name			
78. Names of other biological/adopted minor children he/she supports				Birthdate		Address	
79. Is this party pregnant? a. When is the child due? b. Is the party in this case the biological parent of the expected child? 80. Is this party married? ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No							
81. Occupation				82. Employer (if unemployed, name of last employer)			
83. Employer's address		City		State		Zip	
84. Date hired							
85. Gross earnings per pay period (earnings before taxes)						86. Average overtime hours for past 12 months	
87. Medical insurance company name, address, telephone no.						Policy/Group number Beginning date, if known	
88. Dental insurance company name, address, telephone no.						Policy/Group number Beginning date, if known	
89. Optical insurance company name, address, telephone no.						Policy/Group number Beginning date, if known	
90. What dependent coverage is available to the other parent without cost? ☐ Medical ☐ Dental ☐ Optical							
91. What dependent coverage is available by payment of an additional premium? (Specify cost per pay period.) ☐ Medical _____ per _____ ☐ Dental _____ per _____ ☐ Optical _____ per _____							
92. Individuals currently covered by other parent's insurance							
Name		Birthdate		Relationship		Medical () Dental () Optical ()	

If you want friend of the court services, you must check the box below.

☐ **I request child-support services pursuant to the child-support enforcement program of Title IV-D of the Social Security Act.**

I declare under the penalties of perjury that this questionnaire has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

Date

Signature

Reminder List

- Have you signed this questionnaire?
- Have you completed item 21 regarding the number of overnights you have with the child annually? Failure to specify will result in the friend of the court estimating the number of overnights.
- Have you attached your four most recent paycheck stubs, or a statement from your employer(s) of wages and deductions and year-to-date earnings?
- Have you attached a copy of your last federal and state income tax returns, including all schedules, W-2s, and 1099s? If self-employed, also attach a copy of your three most recent business tax returns and/or corporation returns.
- Attach any additional information that may be useful to the friend of the court in making a support recommendation. Make sure you use enough postage to cover these additional items.
- Have you attached the Child Care Verification (form FOC 39e) if you are asking for reimbursement of child-care expenses?
- Make a copy of this form for your own records.
- Send the original form, completed and signed, to the friend of the court office.

STATE OF MICHIGAN SIXTH JUDICIAL CIRCUIT OAKLAND COUNTY	CHILD CARE VERIFICATION	CASE NO.
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FRIEND OF THE COURT
P.O. BOX 436012
PONTIAC MI 48343
(248) 858-0424

PARENT INFORMATION

COMPLETE THE TOP PORTION OF THIS FORM AND HAVE YOUR CHILDCARE PROVIDER COMPLETE THE REMAINDER.
IT IS YOUR RESPONSIBILITY TO RETURN THE COMPLETED FORM TO THE FRIEND OF THE COURT.

Name					
Name(s) and age(s) of child(ren) involved in this case:					
Are you receiving financial assistance for childcare from any federal or state agency? ☐ Yes ☐ No					
If yes, please state the agency and the amount you are receiving.					

CHILDCARE PROVIDER INFORMATION

Please attach a schedule of your most recent child care rates.

The Child Care Provider(s) must complete the remainder of this form for the above named child(ren)

Name of provider			Address		
City	State	Zip	County	Area code & Telephone no.	
Name & age of child		School year rates	Average number of hours/week	Hourly rate	Total weekly rate
Name of provider			Address		
City	State	Zip	County	Area code & Telephone no.	
Name & age of child		School year rates	Average number of hours/week	Hourly rate	Total weekly rate

Do you require payment services even when children are absent to guarantee a position in your center?

☐ Yes ☐ No If yes, please explain:

Does a Federal or State agency or a public or private entity contribute all or a portion of these child care services?

☐ Yes ☐ No If yes, please provide agency name and amount contributed.

The above information is provided to enable the Friend of the Court to accurately report childcare costs in making a child support recommendation. I certify that the above information is true, accurate and complete.

Date

Signature and title of provider

**OVERNIGHT PARENTING TIME
&
HIGH SCHOOL COMPLETION DATE
VERIFICATION FORM**

When calculating child support and determining the month support should terminate, the Friend of the Court requires each parent to provide the following information:

Child's Name	Annual Overnights with Mother	Annual Overnights with Father	Current Grade	Anticipated Last Mo. & Yr. of HS*
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____
8. _____	_____	_____	_____	_____
9. _____	_____	_____	_____	_____

*The "Anticipated Last Mo. & Yr. of High School" is the anticipated month and year the child will stop attending high school on a full-time basis rather than the month and year of graduation, which may be later in time.

Additional Information:

I certify that the above information is true, accurate, and complete.

Date: _____

Signature _____

Printed Name _____

Case No. _____

**OVERNIGHT PARENTING TIME
&
HIGH SCHOOL COMPLETION DATE
NOTICE**

Please note, the failure to provide the requested information may result in: The Friend of the Court determining the number of annual overnights the child(ren) spend(s) with each parent; and/or, Child support stopping before the child(ren) complete(s) high school.

If both parties fail to respond to this notice and your current order allows for **reasonable and/or liberal parenting time**, the Friend of the Court will assume that the non-custodial parent exercises **75 overnights annually**.

If both parties fail to respond to this notice and your current order allows for a **specific parenting time schedule**, the Friend of the Court will use the number of overnights the non-custodial parent is awarded under that order when determining child support.

If only one party responds to this notice, the Friend of the Court will use the numbers he or she provided for determining support and the ending date.

If the parties do not agree to the number of overnights, the Friend of the Court will use the actual court order for determining support in the absence of credible evidence otherwise.

If both parties fail to provide the last anticipated month and year each child will attend high school on a full-time basis, then support will be payable through the end of the month of the year the child turns 18. Support may be extended thereafter if one of the parties files a motion and provides proof of the month and year each child will stop attending high school on a full-time basis.