

FRIEND OF THE COURT
Susan M. Borovich



ASSISTANT FRIEND OF THE COURT
Rena Topolewski

ST. CLAIR COUNTY FRIEND OF THE COURT
31st Judicial Circuit
201 McMorran Blvd., Room 1600
Port Huron, Michigan 48060
Phone (810) 985-2285
www.stclaircounty.org/offices/foc

**Do not submit originals. Your documentation will not be returned to you.
Any copies requested at the Friend of Court office will be assessed a copy fee.**

REQUEST FOR INFORMATION

You must provide the following along with completing the attached:

- 4 Current paystubs and last years W-2 Forms (If self employed or receive 1099s- last 3 years taxes)
- Childcare verification form completed, with attached pricelist from childcare provider, and signed by provider
- Complete name and address of employer(s)
- Proof of unemployment benefits
- Health insurance verification and cost (if any) verification for the children
- Other: _____

You must provide all information above prior to or at the time of the hearing. If the person requesting the hearing fails to appear for hearing or contact the office at the time of the hearing, their request may be dismissed. If either party fails to provide verification of employment, or income, an ability to earn may be imputed based on last known wage or an ability to earn a wage associated with their profession. A Show Cause hearing may be scheduled to compel release of information if either party fails to provide verification of any of the above information.

THE MICHIGAN CHILD SUPPORT FORMULA AND/OR SPOUSAL SUPPORT PROGNOSTIGATOR WILL BE USED. IF SUPPORT IS CURRENTLY ORDERED, THIS MAY CAUSE A RAISE OR REDUCTION IN YOUR SUPPORT.

Case No: _____

Plaintiff's Name: _____ Attorney: _____

Defendant's Name: _____ Attorney: _____

If you are requesting Friend of the Court services, you must sign below.

I request child support services under the child support enforcement program of Title IV-D of the Social Security Act, by signing below.

I declare that the attached information is accurate and true to the best of my information, knowledge and belief.

Date: _____ Signature: _____

If you are not requesting Friend of Court Services, then you must opt out of Friend of the Court Services.



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HEALTH INSURANCE INFORMATION

Please verify current health insurance information for children on this case.

- Court Docket No:
- Client Name:
- Name of Children Insured:
- Policy Holder if other than client:
- Name of Employer:

Medical Insurance: _____ Claim Address: _____ City, State, Zip: _____ Phone No.: _____	Date Effective: _____	Policy No.: _____ Group No.: _____ Contract No.: _____
Optical Insurance: _____ Claim Address: _____ City, State, Zip: _____ Phone No.: _____	Date Effective: _____	Policy No.: _____ Group No.: _____ Contract No.: _____
Dental Insurance: _____ Claim Address: _____ City, State, Zip: _____ Phone No.: _____	Date Effective: _____	Policy No.: _____ Group No.: _____ Contract No.: _____
Prescription Insurance: _____ Claim Address: _____ City, State, Zip: _____ Phone No.: _____	Date Effective: _____	Policy No.: _____ Group No.: _____ Contract No.: _____
Other Insurance: _____ Claim Address: _____ City, State, Zip: _____ Phone No.: _____	Date Effective: _____	Policy No.: _____ Group No.: _____ Contract No.: _____

Completed by: _____ Phone: _____
Date: _____

201 MCMORRAN BLVD Room 1600, PORT HURON, MICHIGAN
48060

(810) 985-2285

Plaintiff name

V

Defendant name

GENERAL INFORMATION

1. Your full name (first, middle, & last)			2. Date of birth		3. Place of birth: City and State		
4. Address		City		State	Zip	5. Home telephone	
6. Social security number				7. Driver license number		8. Work telephone	
9. Sex <input type="checkbox"/> M <input type="checkbox"/> F	10. Eye color	11. Hair color	12. Height	13. Weight	14. Race	15. Scars, tatoos, etc.	
16. Your father's full name				17. Your mother's full maiden name			
18. Names of all of your dependent children		Birthdate	Soc. Sec. No.		Address		
19. Are you or the other parent in this case pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete a. and b. below.							
a. When is the child due?			b. Are the parties in this case the biological parents of the expected child? <input type="checkbox"/> Yes <input type="checkbox"/> No				

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

20. Full name (first, middle, & last)			21. Date of birth		22. Place of birth: City and State		
23. Address		City		State	Zip	24. Home telephone	
25. Social security number				26. Driver license number		27. Work telephone	
28. Sex	29. Eye color	30. Hair color	31. Height	32. Weight	33. Race	34. Scars, tattoos, etc.	
35. Father's full name				36. Mother's full maiden name			
37. Names of all the other parent's dependent children		Birthdate	Soc. Sec. No.		Address		

INCOME INFORMATION

38. Your occupation		39. Your employer (if unemployed, name of last employer)		
40. Employer's address		City	State	41. Date hired
42. Gross earnings per pay period (earnings before taxes) \$ <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> bi-monthly <input type="checkbox"/> monthly		43. Social security number		
44. Hourly pay rate (including shift premium and COLA)		46. Avg. overtime hours for past 12 months		
47. Second job		48. Employer		
49. Employer's address		City	State	50. Date hired
51. Gross earnings per pay period (earnings before taxes) \$ <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> bi-monthly <input type="checkbox"/> monthly		52. Hourly pay rate	53. Avg. of hours worked per pay period since hire date	
54. List MONTHLY income from all other sources, such as:				

- | | |
|---------------------------|----------------------------------|
| Commissions | Social Security Benefits |
| Bonuses | V.A. Benefits |
| Profit Sharing | Disability Insurance |
| Interest | G.I. Benefits |
| Dividends | Nat'l Guard & Res. Drill Pay |
| Annuities | Armed Services |
| Pensions/Longevity | Allowance for Rent |
| Deferred Compensation/IRA | Rental Income |
| Trust Funds | Spousal Support/Alimony |
| Unemployment Benefits | General Assistance |
| Strike Pay | AFDC |
| SUB Pay | Supplemental Security Income SSI |
| Sick Benefits | Other |
| Workers Compensation | |

55. Do you have any other alimony or child support order? No Yes, as payer Yes, as recipient If so, complete a, b, and c.

a. Amount of order (do not include arrearages)	b. Type of order/Case No	c. City, County and State
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Do you provide the sole support for stepchildren residing in your home because support is unavailable from both natural/adoptive parents?
 No Yes If Yes, how many stepchildren do you support?

If yes, state the reason the stepchildren's mother is unable to provide support:
 If yes, state the reason the stepchildren's father is unable to provide support:

57. Do any of the children listed on item 18 receive payments from the Social Security Administration? Yes No

Child's Name	Amount (monthly)	Type of benefit SSI	(check one) Dependent Benefit	Source of dependent benefit (Mother, Father, Stepparent)
	*			

58. Attach your 4 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.

STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY	CHILD CARE VERIFICATION	CASE NO.
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Court address

Court telephone no.

PARENT INFORMATION

Complete the top portion of this form and have your child care 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 child care from any Federal or State agency: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state the agency and the amount your are receiving.

CHILD CARE PROVIDER INFORMATION

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

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

Name of provider		Address			
City	State	Zip	County	Area Code and Telephone no.	
Name and Age of Child	School Year Rates		Avg. No. of Hours/Week	Hourly Rate	Total Weekly Rate
Name and Age of Child	Summer Season Rates		Avg. No. of Hours/Week	Hourly Rate	Total Weekly Rate
Do you require payment for services even when children are absent to guarantee a position in your center? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:					
Does a Federal or State agency contribute all or a portion of these child care services? <input type="checkbox"/> Yes <input type="checkbox"/> 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 child care costs in making a child support recommendation. I certify that the above information is true, accurate, and complete.					
Date _____			Signature and title of provider _____		

FRIEND OF THE COURT INCOME WORKSHEET
FOR NEW CASES FOR CHILD SUPPORT, CUSTODY, PARENTING TIME AND MEDICAL

Each parent must fully complete and then return this form so support can be calculated.

As of 10-01-08, support is based on the number of overnights each parent has with the child(ren). List each child's names and then specify the number of overnights with each parent. This is for all children.
 (i.e. the FOC parenting time schedule is 78 overnights; week to week,-shared equal time- is 182.5 overnights @ parent)

Child's name _____ # overnights with mother _____ # overnights with father _____
 Child's name _____ # overnights with mother _____ # overnights with father _____
 Child's name _____ # overnights with mother _____ # overnights with father _____
 Child's name _____ # overnights with mother _____ # overnights with father _____
 Child's name _____ # overnights with mother _____ # overnights with father _____

Marital Status: **Married** **Single** **Head Of Household**

How many other biological or legally adopted (not step-children) minor children do you have in your home?
First and last name of other child(ren) and date of birth (1) _____ (2) _____
(3) _____ (4) _____ (5) _____

Are you now receiving food stamps? _____ Medicaid? _____ TANF grant? _____

Total amount you pay per month for health insurance \$ _____ or Paid by employer
(total for all premiums paid for health insurance, dental, optical and/or prescription)
How many persons are covered by this policy [total number of adult(s) and children]

List any other child support cases you have below:

County	Name/Docket Number	Monthly Obligation

Do you have child care expenses for the minor child(ren) in this case during the year Yes No
If so Complete the Childcare verification form on back

REMINDER LIST:

- Have you signed the front of your questionnaire?
- Have you attached your four(4) most recent paystubs, or Taxes if 1099 or self employed?
- Have you completed your childcare verification form on back if applicable?
- Have you made a copy for your own records?