XRMP

FRIEND OF THE COURT
Renae Topolewski

ASSISTANT FRIEND OF THE COURT
Ronald J. Kaski

ST. CLAIR COUNTY FRIEND OF THE COURT
31st Judicial Circuit
201 McMorran Blvd., Room 1600
Port Huron, Michigan 48060
Phone (810) 985-2285
foc@stclaircounty.org
http://www.stclaircounty.org/offices/14

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 year's W-2 Forms (If self-employed or receive 1099s send 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 PROGNOSTICATOR 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 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 Court services.

To the Clerk: For FOC office

STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY	FRIEND OF THE COURT CASE QUESTIONNAIRE	CASE NO. and JUDGE

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 earings 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	Type of benefit (check one) 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.

Reason	Estimated number of hours per week
☐ 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.

Case No. _____

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? ☐ Yes ☐ No	a. When is the child due?	b. Is the party in this case the biological parent of the expected child? ☐ Yes ☐ No	80. Is this party married? ☐ 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.

Approved, SCAO

Original - Friend of the court
Additional copies as needed

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

Friend of the court address **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

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 child(ren) named above.

Name of provider		Address		
City	State	Zip	County	Area code and Telephone no.

Name and Age of Child	**School Year Rates**	Average No. of Hours/Week	Hourly Rate	Total Weekly Rate

Name and Age of Child	**Summer Season Rates**	Average 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? ☐ Yes ☐ No
If yes, please explain.

Does a federal or state agency or a public or private entity contribute all or a portion of the cost of child-care services? ☐ Yes ☐ No
If yes, please provide the agency name and amount contributed.

The information above 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 information provided above 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 10-1-08, support is based on the number of overnights each parent has with the child(ren). List each child's name 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)

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 stepchildren) 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 adults and children) _____

List any other child support cases you have:

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 Child Care Verification attached.

REMINDER LIST:

Have you signed the front of your questionnaire?

Have you attached your four most recent paystubs or taxes if 1099 or self-employed?

Have you completed your childcare verification form, if applicable?

Have you made a copy for your own records?