



**ST. CLAIR COUNTY FRIEND OF THE COURT**

31<sup>st</sup> 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.

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

Telephone no.

Plaintiff	<b>v</b>	Defendant
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**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 <input type="checkbox"/> M <input type="checkbox"/> 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?	a. When is the child due?		b. Is the other party in this case the biological parent of the expected child?			24. Are you presently married?		
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> 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) \$ <input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> bimonthly <input type="checkbox"/> monthly					30. Filing status _____ dependents claimed <input type="checkbox"/> married <input type="checkbox"/> single <input type="checkbox"/> 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) \$ <input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> bimonthly <input type="checkbox"/> 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) \$ <input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> bimonthly <input type="checkbox"/> 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. <input type="checkbox"/> No <input type="checkbox"/> Yes, as payer <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No			
47. What is your educational background? (Check one)			
<input type="checkbox"/> less than high school	<input type="checkbox"/> High school graduate	<input type="checkbox"/> Trade school graduate	
<input type="checkbox"/> Associate's degree	<input type="checkbox"/> Bachelor's degree	<input type="checkbox"/> 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? <div style="text-align: center;"> <input type="checkbox"/> Medical                      <input type="checkbox"/> Dental                      <input type="checkbox"/> Optical                 </div>		
52. What dependent coverage is available by payment of an additional premium? (Specify cost per pay period.) <input type="checkbox"/> Medical _____ per _____ <input type="checkbox"/> Dental _____ per _____ <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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>		
<input type="checkbox"/> Work related	_____		
<input type="checkbox"/> Looking for employment	_____		
<input type="checkbox"/> 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.  _____  _____
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**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 <input type="checkbox"/> M <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	a. When is the child due?		b. Is the party in this case the biological parent of the expected child? <input type="checkbox"/> Yes <input type="checkbox"/> No			80. Is this party married? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Optical								
91. What dependent coverage is available by payment of an additional premium? (Specify cost per pay period.) <input type="checkbox"/> Medical _____ per _____ <input type="checkbox"/> Dental _____ per _____ <input type="checkbox"/> 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.

<b>STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY</b>	<b>CHILD-CARE VERIFICATION</b>	<b>CASE NO.</b>
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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	<b>School Year Rates</b>	Average No. of Hours/Week	Hourly Rate	Total Weekly Rate	
Name and Age of Child	<b>Summer Season Rates</b>	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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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?