

<b>STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY</b>	<b>FRIEND OF THE COURT CASE QUESTIONNAIRE (Page 1)</b>	<b>CASE NO.</b>
Friend of the court address		Telephone no.
<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="border: 1px solid black; width: 40%; height: 30px; margin-bottom: 5px;"></div> <div style="text-align: center; width: 10%; font-weight: bold;">v</div> <div style="border: 1px solid black; width: 40%; height: 30px; margin-bottom: 5px;"></div> </div>		
<b>Complete this form and sign on page 4.</b>		
<b>YOUR GENERAL INFORMATION</b>		
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   Anticipated graduation date   No. of overnights you have w/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?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
24. Are you presently married?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>YOUR INCOME, MEDICAL, EDUCATIONAL, AND HEALTH INSURANCE INFORMATION</b>		
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
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		

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

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? ☐ 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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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)	Source of dependent benefit (mother, father, stepparent)
		SSI <input type="checkbox"/> Dependent benefit <input type="checkbox"/>	

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? ☐ Yes ☐ No

If yes, please explain medical condition/restriction: \_\_\_\_\_

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

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 ( )
_____					
_____					
_____					

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**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>
<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
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**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 number		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? 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?					
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<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.	

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**INFORMATION REGARDING THE OTHER PARENT IN THIS CASE (continued)**

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 that the information in this questionnaire is 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.