

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 <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 <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.) <div style="text-align: center;"><input type="checkbox"/> Medical _____ per _____ <input type="checkbox"/> Dental _____ per _____ <input type="checkbox"/> Optical _____ per _____</div>		
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.

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?		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			
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 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.