

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
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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																				
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																							
<table border="1"> <thead> <tr> <th>Child's Name</th> <th>Amount (monthly)</th> <th>Type of benefit (check one)</th> <th>Source of dependent benefit (mother, father, stepparent)</th> </tr> <tr> <th>SSI</th> <th>Dependent benefit</th> <td colspan="2"></td> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td colspan="2"></td> </tr> <tr> <td></td> <td></td> <td colspan="2"></td> </tr> <tr> <td></td> <td></td> <td colspan="2"></td> </tr> </tbody> </table>				Child's Name	Amount (monthly)	Type of benefit (check one)	Source of dependent benefit (mother, father, stepparent)	SSI	Dependent benefit														
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SSI	Dependent benefit																						
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) <table border="0"> <tr> <td><input type="checkbox"/> less than high school</td> <td><input type="checkbox"/> High school graduate</td> <td><input type="checkbox"/> Trade school graduate</td> </tr> <tr> <td><input type="checkbox"/> Associate's degree</td> <td><input type="checkbox"/> Bachelor's degree</td> <td><input type="checkbox"/> Graduate degree</td> </tr> </table>				<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														
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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?	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Optical				
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.			
Reason	<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 ()
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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.