Approved, SCAO .

STATE OF MICHIGAN 39TH JUDICIAL CIRCUIT LENAWEE COUNTY	FRIEND OF THE COURT CASE QUESTIONNAIRE (Page 1)	CASE NO.

Friend of the court address
425 N. MAIN STREET ADRIAN MI 49221

Telephone no.
517-264-4706

Plaintiff	v	Defendant

Complete this form and sign on page 4.

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 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? ☐ Yes ☐ No | ☐ 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

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
Postition 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

Approved, SCAO

STATE OF MICHIGAN 39TH JUDICIAL CIRCUIT LENAWEE COUNTY	FRIEND OF THE COURT CASE QUESTIONNAIRE (Page 2)	CASE NO.

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?
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? ☐ Yes ☐ No
If yes, please explain medical condition/restriction:

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

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 ( )

Approved, SCAO

STATE OF MICHIGAN 39TH JUDICIAL CIRCUIT LENAWEE COUNTY	FRIEND OF THE COURT CASE QUESTIONNAIRE (Page 3)	CASE NO.

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.

_____

_____

_____

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 ☐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.

Approved, SCAO

STATE OF MICHIGAN 39TH JUDICIAL CIRCUIT LENAWEE COUNTY	FRIEND OF THE COURT CASE QUESTIONNAIRE (Page 4)	CASE NO.

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?
☐ 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 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.

Approved, SCAO

Original - Friend of the court
Additional copies as needed

STATE OF MICHIGAN 39TH JUDICIAL CIRCUIT LENAWEE COUNTY	CHILD-CARE VERIFICATION	CASE NO.

Friend of the court address

425 N. MAIN STREET ADRIAN MI 49221

Telephone no.

(517) 264-4706

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

THE THIRTY-NINTH JUDICIAL CIRCUIT OF MICHIGAN

Circuit Judges
MARGARET M.S NOE
ANNA MARIE ANZALONE

Court of Lenawee
Rex B Martin Building
Adrian, Michigan 49221

KRISTI DRAKE
Friend of the Court
P.O. Box 577
Adrian, MI 49221
Phone: (517) 264-4706
Fax: (517) 264-4765

HEALTH CARE COST

1. What is your monthly cost of health care insurance?

_____

2. What is your monthly cost of individual coverage through your employer?

_____

3. How many children on this Order are covered under your present insurance plan?

_____

4. Do you have any stepchildren or other children that are covered under your present insurance plan?

_____

PLEASE LIST THE PEOPLE THAT PRESENTLY LIVE IN YOUR HOME

	NAME	RELATIONSHIP	AGE
1.			
2.			
3.			
4.			
5.			
6.			
7.			

OVERNIGHTS

Please list how many overnights per month the minor child(ren) on THIS Order are with you(for calculation purposes only):

_____

_____