

<b>STATE OF MICHIGAN 25th JUDICIAL CIRCUIT MARQUETTE COUNTY</b>	<b>FRIEND OF THE COURT CASE QUESTIONNAIRE (Page 1)</b>	<b>CASE NO.</b>  Please return within 10 days.
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Friend of the court address 234 W Baraga Ave., Marquette, MI 49855	Telephone no. phone 225-8262 / fax 225-8274
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Plaintiff	<b>v</b>	Defendant
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**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 <input type="checkbox"/> M <input type="checkbox"/> F	13. Eye color	14. Hair color	15. Height	16. Weight	17. Race
19. Your father's full name			20. Your mother's full maiden name		
21. Names of children in common with other parent in this case Birthdate Gender Soc. sec. no. Address No. of overnights you have w/ child annually					
22. Names of all additional minor children you support Birthdate Address					
23. Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		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	
				24. Are you presently married? <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"/> <input type="checkbox"/> <input type="checkbox"/>	
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 _____	Worker's 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 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 <input type="checkbox"/> Dependent benefit <input type="checkbox"/>	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:  Yes  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

48. Medical insurance company name, address, telephone no. Policy number Beginning date, if known

49. Dental insurance company name, address, telephone no. Policy number Beginning date, if known

50. Optical insurance company name, address, telephone no. Policy 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 ( <input type="checkbox"/> )	Dental ( <input type="checkbox"/> )	Optical ( <input type="checkbox"/> )

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<b>YOUR CHILD-CARE INFORMATION</b>		
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	
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
<b>YOUR ADDITIONAL INFORMATION</b>		
57. List any additional information that would be useful to the court in making a support recommendation.		
_____		
_____		
<b>INFORMATION REGARDING THE OTHER PARENT IN THIS CASE (if known)</b>		
58. Full name		59. Date of birth
		60. Place of birth: city and state
61. Address		62. Home telephone
City	State	Zip
		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	70. Eye color	71. Hair color
<input type="checkbox"/> M <input type="checkbox"/> F		
72. Height	73. Weight	74. Race
		75. Scars, tattoos, etc.
76. Father's full name		77. Mother's full maiden name
78. Names of all additional 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 parent married? <input type="checkbox"/> Yes <input type="checkbox"/> No
81. Occupation		82. Employer (if unemployed, name of last employer)
83. Employer's address		84. Date hired
City	State	Zip
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 number	Beginning date, if known
88. Dental insurance company name, address, telephone no.	Policy number	Beginning date, if known
89. Optical insurance company name, address, telephone no.	Policy 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 ( <input type="checkbox"/> )    Dental ( <input type="checkbox"/> )    Optical ( <input type="checkbox"/> )
_____		
_____		
_____		

**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.**

\_\_\_\_\_ Date

\_\_\_\_\_ Signature

**Reminder List**

- Have you signed this questionnaire?
- 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.

## OVERNIGHT PARENTING TIME VERIFICATION

As of October 1, 2008, the Michigan Child Support Formula factors in the number of annual overnights each parent exercises when determining child support.

In order to calculate the support order, the Friend of the Court requires each parent to complete the following section:

### STATE THE NUMBER OF OVERNIGHTS PER YEAR THE CHILD(REN) SPENDS WITH:

Mother \_\_\_\_\_

Father \_\_\_\_\_

I certify that the above information is true, accurate, and complete.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

Case No. \_\_\_\_\_

Please note that failure to respond to this request or agree on the amounts may result in the Friend of the Court making a determination as to the number of annual overnights the child(ren) spend with each parent.

If both parties fail to respond to this notice and your current order allows for **reasonable and/or liberal parenting time**, the Friend of the Court will assume that the non-custodial parent exercises **75 overnights annually**.

If both parties fail to respond to this notice and your current order allows for a **specific parenting time schedule**, the Friend of the Court will determine the amount of overnights the non-custodial parent is awarded under that order and use it for determining child support.

If only one party responds to this notice, the Friend of the Court will use the numbers he or she provided for determining support.

If the parties do not to agree to the number of overnights, the Friend of the Court will use the actual court order for determining support in the absence of credible evidence otherwise.