To the Clerk: For FOC office

STATE OF MICHIGAN 48TH JUDICIAL CIRCUIT ALLEGAN 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 ☐ 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	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?
☐ Yes ☐ No		☐ Yes ☐ No	☐ 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

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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)	39. Hourly pay rate	40. Average hours worked per pay period since hire date
$ ☐ weekly ☐ biweekly ☐ bimonthly ☐ monthly		

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 earings per pay period (earnings before taxes)
$ ☐ weekly ☐ biweekly ☐ bimonthly ☐ 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. ☐ 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	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

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

	Policy/Group number	Beginning date, if known
48. Medical insurance company name, address, telephone no.		
49. Dental insurance company name, address, telephone no.		
50. Optical insurance company name, address, telephone no.		

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 ( )

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.

____

____

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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 ☐ 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

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 ( )

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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 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.

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RESIDENCE HISTORY

How long at present address? ___________________

Three Previous Addresses	From—To--	Reason for Moving	Other Occupants

ALL PEOPLE WHO LIVE IN YOUR HOUSEHOLD

Name	Date of Birth	Driver's License #	Social Security #

EMPLOYMENT

Most Recent First

From—To--	Employer	Reason for Leaving

RELIGION

Do you attend church?	How Often?	Name of church:
Do the children attend church?	How Often?	Name of church:

MARITAL HISTORY

To Whom	Date and Place of Marriage	Date/Place of Separation/Divorce

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PERSONAL HISTORY

Have you ever experienced a problem associated with substance abuse and/or drinking alcohol to excess? ☐ **YES** ☐ **NO**
Explain:

Has your spouse, former spouse or the other party involved in this action experienced a problem with substance abuse and/or drinking alcohol to excess? ☐ **YES** ☐ **NO**
Explain:

Have you ever been arrested? If so, when and for what reason?
Has the other party ever been arrested?
Have you or the other party ever participated in marriage, couples or personal counseling?
If yes, what was the counselor's name?
Do you or the other party have any physical health problems?

ABOUT THE MINOR CHILD OR CHILDREN BETWEEN THE PARTIES

Name	School	Grade	Teacher

Are any of the children experiencing academic problems in school? If yes, explain

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MEDICAL PROVIDER

Primary physician or pediatrician for the child or children. NAME:	
Address:	Telephone:
How long has the doctor been attending to the child or children?	

PARENTING TIME

What is the parenting time schedule being exercised at this time?
What was the date of last parenting time with the other parent?
Do you have objections to parenting time? ☐ **YES** ☐ **NO**
If so, what are your specific objections?
How many overnights is (are) the child(ren) with you per week?
Is parenting time ordered by the court? ☐ **YES** ☐ **NO**
How would you describe the attitudes of the children toward the other parent?
Do any of the children have special needs physically, educationally, or emotionally?
How would you describe the effect of the parental separation or divorce on the children?

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Why do you feel you should have custody?

Why do you feel the other parent should NOT have custody?

Approved, SCAO

Original - Friend of the court
Additional copies as needed

STATE OF MICHIGAN 48TH JUDICIAL CIRCUIT ALLEGAN COUNTY	CHILD-CARE VERIFICATION	CASE NO.

Friend of the court address | Telephone no.

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