Approved, SCAO

STATE OF MICHIGAN 36th JUDICIAL CIRCUIT VAN BUREN COUNTY	FRIEND OF THE COURT CASE QUESTIONNAIRE (Page 1)	CASE NO.

Friend of the Court Office
36th Judicial Circuit Court 219 Paw Paw Street, Lower Level
Paw Paw, MI 49079

Telephone: (269) 657-7734

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? ☐ Yes ☐ No	a. When is the child due?	b. Is the other party in this case the biological parent of the expected child? ☐ 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

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

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 ( )

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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.

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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.