ST. JOSEPH COUNTY FRIEND OF THE COURT

Address: 920 W Michigan Ave, Three Rivers, MI 49093 Phone: (269) 467-5570 Fax: (269) 467-5579

REQUEST FOR CONSENT ORDER TO CHANGE
CUSTODY, PARENTING TIME, CHILD SUPPORT, OR CHILD CARE

NOTE: The Friend of the Court reserves the right to reject this agreement, if necessary. If an attorney represents either party, the attorney **must** prepare any Consent Order. **Both parties must review this form before submitting.**

Court Order Number:_____

Plaintiff's Name, DOB, SS#, Address, Phone #.	Defendant's Name, DOB, SS#, Address, Phone #.

Minor child(ren):
Full Name:_____ DOB:_____ SSN:_____
Full Name:_____ DOB:_____ SSN:_____
Full Name:_____ DOB:_____ SSN:_____

THIS BOX MUST BE COMPLETED OR THE ORDER WILL NOT BE DRAFTED
Are you receiving any of the following forms of public assistance: (check all boxes that apply).
( )Cash assistance ( )Child care assistance ( )Medicaid ( )Food stamps ( )None
IF THE CUSTODIAL PARENT IS RECEIVING ANY FORM OF PUBLIC ASSISTANCE, THEN THE PARTIES CANNOT USE THIS FORM TO CHANGE CHILD SUPPORT

CHECK ONLY THE PROVISIONS TO BE CHANGED:
CUSTODY:
Joint legal custody: _____Yes _____No

Physical custody: _____Mom _____Dad _____Joint

PARENTING TIME:
_____Per the St. Joseph County Parenting Policy

_____Other:_____

_____

CHILD SUPPORT AND CHILD CARE:
Do you want the Friend of the Court to determine the Child Support an/or Child Care amount? ___YES ___NO

The new child support amount: $_____per month per child for_____child(ren) for a total of $_____

# of overnights with Plaintiff_____; # of overnights with Defendant_____

When will this new amount begin?_____**(Must be the 1st day of any given month)**

Do you wish to forgive arrears? Child Support Arrears ___YES ___NO In the amount of $_____
or thru the end of the month of _____.

If you are agreeing on an amount other than what the Michigan Child Support Formula states, you must state the reason why:_____

PLAINTIFF'S EMPLOYER:_____
(name, address and telephone)
DEFENDANT'S EMPLOYER:_____
(name, address and telephone)

MEDICAL INSURANCE:

Who is responsible for health care insurance? ___DAD ___MOM ___BOTH

What percentage of uninsured health care expenses will be paid by DAD____% MOM____%

DOMICILE: Change child's domicile to State of:_____
Who will provide transportation after domicile change:_____

_____

I HEREBY DECLARE THE ABOVE TO BE TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

DATE:_____ PLAINTIFF'S SIGNTURE:_____

DATE:_____ DEFENDANT'S SIGNATURE:_____

INSTRUCTIONS FOR COMPLETING A REQUEST FOR CONSENT ORDER TO CHANGE CUSTODY, PARENTING TIME, CHILD SUPPORT OR CHILD CARE

IF THE PARTY HAVING CUSTODY OF THE CHILD(REN) IS ON PUBLIC/STATE ASSISTANCE, (FIP,FOOD STAMPS, MEDICAID) YOU MAY NOT CHANGE SUPPORT

THIS FORM IS TO ASK THE FRIEND OF THE COURT (FOC) TO PREPARE AN ORDER TO CHANGE A CURRENT ORDER. **Please complete all sections that apply**.

GENERAL INFORMATION: This information is necessary to complete the consent order. It must be provided.

CHILD SUPPORT: If the parent having custody of the child(ren)**is not** receiving any form of public assistance, the parties may agree upon the amount of support with the understanding that the child(ren) is/are entitled to the amount recommended by the Michigan Child Support Formula and that the parent having custody is able to meet the needs of the child(ren) with the agreed upon amount. **If you wish to stop child support you must contact the FOC to make sure you can consent to this or if you have to petition.** If this section is left blank, the FOC will insert the amount pursuant to the last order of support. If you are deviating from the Formula, you must state the reason why.

NOTICE

AFTER THIS FORM IS SUBMITTED, THE FOC WILL PREPARE THE ACTUAL ORDER, WHICH MUST ALSO BE SIGNED BY BOTH PARTIES. ONE PARTY MUST CONTACT THE FOC TO SCHEDULE A TIME WHEN BOTH PARTIES CAN APPEAR AT THE FOC OFFICE TO READ AND SIGN THE ORDER.

FOR QUESTIONS AND TO SCHEDULE THE APPOINTMENT CALL 269-467-5570