

<b>STATE OF MICHIGAN 45th JUDICIAL CIRCUIT ST. JOSEPH COUNTY</b>	<b>FRIEND OF THE COURT CASE QUESTIONNAIRE</b>	<b>CASE NO. and JUDGE HON. ROBERT PATTISON</b>
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Friend of the Court  
920 W MICHIGAN AVE THREE RIVERS, MI 49093

Telephone: (269) 467-5570

Plaintiff	v	Defendant
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**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 <input type="checkbox"/> M <input type="checkbox"/> 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? <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"/> married <input type="checkbox"/> single <input type="checkbox"/> 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								

<b>YOUR INCOME, MEDICAL, EDUCATIONAL, AND HEALTH INSURANCE INFORMATION (continued)</b>
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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		
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) \$ [ ] 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? 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	

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

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? <div style="text-align: right;"> <input type="checkbox"/> Medical                      <input type="checkbox"/> Dental                      <input type="checkbox"/> Optical </div>		
52. 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 _____		
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? <span style="float: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</span>			
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.			
<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

**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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<b>INFORMATION REGARDING THE OTHER PARENT IN THIS CASE (if known)</b>
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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 ( )
_____					
_____					
_____					
_____					

**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.

<b>STATE OF MICHIGAN 45th JUDICIAL CIRCUIT ST. JOSEPH COUNTY</b>	<b>CHILD-CARE VERIFICATION</b>	<b>CASE NO. HON. ROBERT PATTISON</b>
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**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	<b>School Year Rates</b>	Average No. of Hours/Week	Hourly Rate	Total Weekly Rate
Name and Age of Child	<b>Summer Season Rates</b>	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? <span style="float:right">[ ] Yes      [ ] No</span> 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? <span style="float:right">[ ] Yes      [ ] No</span> 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		