

## 37<sup>TH</sup> JUDICIAL CIRCUIT COURT – CALHOUN COUNTY, MICHIGAN FRIEND OF THE COURT

**NOTE: The Friend of the Court cannot conduct a support review on a case that is not a qualified support case under Title IV-D of the Social Security Act. If a case is not qualified as a IV-D case due to the receipt of public assistance, at least one party must complete and sign an Application for IV-D Services. If your case is NOT a IV-D case and you want a Friend of the Court Support Review, you MUST check the box at the bottom of the Request For Review of Child Support Form and SIGN where indicated.**

### **INSTRUCTIONS FOR REQUESTING A SUPPORT REVIEW**

Requesting a support review by the Friend of the Court is an alternative to filing a motion for a modification of the support obligation. Parties have an absolute right to file their own motion(s) by employing the services of an attorney or on their own. If you decide to file your own motion, you may request forms and instructions from the Friend of the Court (ask for “Pro Per Forms and Instructions for Modification of Support”). If you request a friend of the court support review, any resulting modification of support will be effective the date of the entry of the new order by the Court. If you file your own motion, the Court may order the change to be effective retroactive to the date your motion is served on the other party.

Under federal and state law, a party to a friend of the court case may request that the friend of the court review his or her support order, 1) not more than once every 36 months, or 2) more frequently if there is a demonstrated **material or significant change in circumstances**. A change in circumstances may include such things as a change in employment or income status for you or the other party. If you are requesting a review less than 36 months from your last support order or modification, you **must specify the change in circumstances that is the basis for your request**.

To request a support review, you must complete and return the Request for Review form, as well as the Friend of the Court Case Questionnaire (FOC 39a-e) and copies of all other information that may be required (follow the instructions in the questionnaire). **If you fail to submit all requested information in a timely manner, your review may not be completed.** You should keep a copy of everything you are submitting, for your own records. Due to the volume of reviews that are requested, it normally takes approximately three months from the receipt of all required information for the review to be completed and a recommendation to be issued. **A modification of support must exceed 10% of the current obligation or \$50 per month (whichever is greater) for the Friend of the Court to recommend modification.**

Child Care: Child care may be ordered through August 31<sup>st</sup> following a child’s 12<sup>th</sup> birthday as a part of the support obligation if such expenses are incurred so that a parent may be employed. These expenses may be incurred by either the custodial or the non-custodial parent. If you are requesting child care reimbursement as part of the support order, you must provide a completed and signed Child Care Verification Form.

<b>STATE OF MICHIGAN</b> <b>37TH JUDICIAL CIRCUIT</b> <b>CALHOUN COUNTY</b>	Friend of the Court Case Questionnaire Page 1	Case No.
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Friend of the Court Address: 161 E. Michigan Ave., Battle Creek, MI 49014 Telephone No. (269) 969-6500

Plaintiff	v.	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. Social security number		7. Driver's license number		8. Work telephone	
9. Sex <input type="checkbox"/> M <input type="checkbox"/> F	10. Eye Color	11. Hair Color	12. Height	13. Weight	14. Race
15. Scars, tattoos, etc.					

16. Names of all of your dependent children	Birthdate	Gender	Natural/Step/Adopted	Address

Is there a parenting time order in effect?  yes  no      Is parenting time being exercised?  yes  no  
 Number of overnights the children are with each parent per year: Plaintiff \_\_\_\_ Defendant \_\_\_\_ (must equal 365)  
 I have evidence of parenting time that is being exercised (such as a calendar)  yes  no      Copy attached  yes  no

17. Are you presently married? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**YOUR INCOME, MEDICAL, EDUCATIONAL, AND HEALTH INSURANCE INFORMATION**

18. Your occupation		19. Your employer (if unemployed, name of last employer)			
20. Employer's address		City	State	Zip	21. Date hired
22. Gross earnings per pay period (earnings before taxes) \$ _____ <input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> bimonthly <input type="checkbox"/> monthly			23. Filing status _____ dependents claimed <input type="checkbox"/> married <input type="checkbox"/> single <input type="checkbox"/> head of household		
24. Hourly pay rate (including shift premium and COLA)		25. Total regular hours worked per pay period		26. Average overtime hours for past 12 months	
27. Second job			28. Employer		
29. Employer's address		City	State	Zip	30. Date hired
31. Gross earnings per pay period (earnings before taxes) \$ _____ <input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> bimonthly <input type="checkbox"/> monthly			32. Hourly pay rate		33. Average hours worked per pay period since hire date

34. 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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FRIEND OF THE COURT ADDRESS:  
161 E. Michigan Ave., Battle Creek, MI 49014-4066

Telephone No.  
(269) 969-6500

Plaintiff (name, address, phone)

v Defendant (name, address, phone)

Pursuant to the Friend of the Court Act [MCL 552.517b], I am requesting that the Friend of the Court conduct a support review on my case.

(Check one)

It has been 36 months since the support order was last modified. The date of the last support order was \_\_\_\_\_.

It has not been 36 months since the last support order, but there has been a significant/material change in circumstances since the last order:

(specify your reasons for requesting review): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that a completed Friend of the Court Case Questionnaire is a part of, and must accompany this request for review. The completed questionnaire is attached. I authorize my employer and any other sources of income to release to the Friend of the Court all information regarding my past, present and future income.

I hereby request support services under the Support Enforcement Program of Title IV-D of the Social Security Act. If necessary, I request the use of the Parent Locator Services. I understand that any information provided to me or on my behalf is to be used only for the purpose of securing child support.

\_\_\_\_\_  
Dated

\_\_\_\_\_  
Printed Name of Requesting Party

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Signature of Requesting Party

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

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 _____

Do you have any other alimony or child support orders?

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
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Do you provide the sole support for stepchildren residing in your home because support is unavailable from both natural/adoptive parents?

No  Yes  If yes, how many stepchildren do you support? \_\_\_\_\_

If yes, state the reason the stepchildren's mother is unable to provide support:

If yes, state the reason the stepchildren's father is unable to provide support:

Do any of the children listed on item 18 receive payments from the Social Security Administration?  Yes  No

Child's Name	Amount (monthly)	Type of benefit (check one)		Source of dependent benefit (Mother, Father, Stepparent)
		SSI	Dependent Benefit	

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.

Do you have any medical conditions/restrictions that affect your ability to work?  Yes  No

If yes, please explain medical condition/restriction:

What is your educational background? (Check one)

Less than High School     
  High School Graduate     
  Trade School Graduate  
 Associates Degree     
  Bachelor's Degree     
  Graduate Degree

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

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

Optical insurance company name, address, telephone no. \_\_\_\_\_ Policy number \_\_\_\_\_ Beginning date, if known \_\_\_\_\_

What dependent coverage is available to you without cost?  Medical  Dental  Optical

What dependent coverage is available by payment of an additional premium? (specify cost per pay period)

O Medical \_\_\_\_\_ per \_\_\_\_\_   
 O Dental \_\_\_\_\_ per \_\_\_\_\_   
 O Optical \_\_\_\_\_ per \_\_\_\_\_

Individuals currently covered by your insurance

Name	Birthdate	Relationship	Medical (√)	Dental (√)	Optical (√)

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**YOUR CHILD CARE INFORMATION**

Do you have child care expenses for the minor children in this domestic relations case during any time of the year?  
 If yes, complete the following information:  Yes  No

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

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 no. of hours per week
<input type="checkbox"/> Work related	_____
<input type="checkbox"/> Looking for employment	_____
<input type="checkbox"/> Enrolled in educational program to improve employment opportunities	_____

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
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**YOUR ADDITIONAL INFORMATION**

List any additional information that would be useful to the court in making a support recommendation

**INFORMATION REGARDING THE OTHER PARENT IN THIS CASE (if known)**

Full name		Date of birth	Place of birth: City and State			
Address	City	State	Zip	Home telephone		
Social security number	Driver's license number			Work telephone		
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Eye color	Hair color	Height	Weight	Race	Scars, tatoos, etc.
Father's full name			Mother's full maiden name			

Names of all his/her dependent children Birthdate Gender Natural/Step/Adopted Soc. Sec. No. Address

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Is this parent married?  Yes  No

Occupation	Employer (if unemployed, name of last employer)
Employer's address	Date hired
City	State
Zip	Average overtime hours for past 12 months
Gross earnings per pay period (earnings before taxes)	

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**INFORMATION REGARDING THE OTHER PARENT IN THIS CASE (continued)**

Medical insurance company name, address, telephone no.	Policy number	Beginning date, if known
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Dental insurance company name, address, telephone no.	Policy number	Beginning date, if known
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Optical insurance company name, address, telephone no.	Policy number	Beginning date, if known
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What dependent coverage is available to the other parent without cost?  Medical  Dental  Optical

What dependent coverage is available by payment of an additional premium? (specify cost per pay period)  
 Medical \_\_\_\_\_ per \_\_\_\_\_  Dental \_\_\_\_\_ per \_\_\_\_\_  Optical \_\_\_\_\_ per \_\_\_\_\_

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 under 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
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**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 for 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 37TH JUDICIAL CIRCUIT CALHOUN COUNTY</b>	<b>CHILD CARE VERIFICATION</b>	<b>CASE NO.</b>
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Court address: 161 E. Michigan Ave., Battle Creek, MI 49014

Court telephone no. (269) 969-6500

**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
Are you receiving financial assistance for child care from any Federal or State agency: <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If yes, please state the agency and the amount your are receiving.

**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 above named child(ren).

Name of provider		Address			
City	State	Zip	County	Area Code and Telephone no.	
Name and Age of Child	School Year Rates		Avg. No. of Hours/Week	Hourly Rate	Total Weekly Rate
Name and Age of Child	Summer Season Rates		Avg. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:					
Does a Federal or State agency contribute all or a portion of these child care services? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide agency name and amount contributed.					
The above information 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 above information is true, accurate, and complete.					
Date			Signature and title of provider		