

**STATE OF MICHIGAN
JUDICIAL CIRCUIT
COUNTY**

MOTION REGARDING SUPPORT

(A) CASE NO.

Court address

Court telephone no.

(B) Plaintiff's name, address, and telephone no. moving party

v

Third party name, address, and telephone no. moving party

Defendant's name, address, and telephone no. moving party

- (C)** 1. a. On _____ a judgment
Date
- or order was entered regarding support.
- b. There is currently no order regarding support.

(D) 2. The plaintiff defendant is ordered to pay support of \$ _____ each _____ .
week, month, etc.

(E) 3. The plaintiff defendant is ordered to pay child care of \$ _____ each _____ .
week, month, etc.

(F) 4. The plaintiff defendant is ordered to pay health care of \$ _____ each _____ .
week, month, etc.

(G) 5. Conditions regarding support have changed as follows:
Use a separate sheet to explain in detail what has happened and attach. Include all necessary facts.

(H) 6. _____ and I have agreed to support as follows:
Name
Use a separate sheet to explain in detail what you have agreed on and attach. Include all necessary facts.

(I) 7. I ask the court to order that support be paid as follows: See 6. above for details.
Use a separate sheet to explain in detail what you want the court to order and attach.

(J) _____
Date Moving party's signature

NOTICE OF HEARING

A hearing will be held on this motion before _____
Judge/Referee

(K) on _____ at _____ at _____ .
Date Time Location

If you require special accommodations to use the court because of a disability, or if you require a foreign language interpreter to help you fully participate in court proceedings, please contact the court immediately to make arrangements. When contacting the court, provide your case number(s).

NOTE: If you are the person receiving this motion, you may file a response. Contact the friend of the court office and request form FOC 51.

CERTIFICATE OF MAILING

I certify that on this date I served a copy of this motion and notice of hearing on the parties or their attorneys by first-class mail addressed to the last-known addresses as defined in MCR 3.203.

(L) _____
Date Moving party's signature

STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY	FRIEND OF THE COURT CASE QUESTIONNAIRE (Page 1)	CASE NO.
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Friend of the court address	Telephone no.			
<table style="width:100%; border: none;"> <tr> <td style="width:45%; border: 1px solid black; height: 20px;">Plaintiff</td> <td style="width:5%; text-align: center; vertical-align: middle;">v</td> <td style="width:50%; border: 1px solid black; height: 20px;">Defendant</td> </tr> </table>	Plaintiff	v	Defendant	
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 <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. Names of children in common with other parent in this case		Birthdate	Gender	Soc. sec. no.	Address	No. of overnights you have w/ child annually	
22. Names of all additional 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		
34. Second job			35. Employer				
36. Employer's address		City	State	Zip	37. Date hired		
38. Gross earnings per pay period (earnings before taxes) \$ <input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> bimonthly <input type="checkbox"/> 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) \$ <input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> bimonthly <input type="checkbox"/> monthly							

STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY	FRIEND OF THE COURT CASE QUESTIONNAIRE (Page 2)	CASE NO.
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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 _____	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 _____

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)

<input type="checkbox"/> Less than high school	<input type="checkbox"/> High school graduate	<input type="checkbox"/> Trade school graduate
<input type="checkbox"/> Associate's degree	<input type="checkbox"/> Bachelor's degree	<input type="checkbox"/> 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 (✓)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY	FRIEND OF THE COURT CASE QUESTIONNAIRE (Page 3)	CASE NO.
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.		
<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
YOUR ADDITIONAL INFORMATION		
57. 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)		
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	70. Eye color	71. Hair color
<input type="checkbox"/> M <input type="checkbox"/> F		
	72. Height	73. Weight
		74. Race
		75. Scars, tattoos, etc.
76. Father's full name		77. Mother's full maiden name
78. Names of all additional minor children he/she supports		Birthdate
		Address
79. Is this party pregnant? a. When is the child due? b. Is the party in this case the biological parent of the expected child?		80. Is this parent married?
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> 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

STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY	FRIEND OF THE COURT CASE QUESTIONNAIRE (Page 4)	CASE NO.
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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? <div style="text-align: center;"> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Optical </div>		
91. 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 _____		
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.