

37TH 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 31st following a child’s 12th 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.

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

STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY	FRIEND OF THE COURT CASE QUESTIONNAIRE	CASE NO. and JUDGE
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Friend of the court address Telephone no.

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		

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

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			
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. <input type="checkbox"/> No <input type="checkbox"/> Yes, as payer <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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	

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? <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
_____	_____	_____	_____

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.

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.

STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY	CHILD-CARE VERIFICATION	CASE NO.
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Friend of the court address

Telephone no.

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	School Year Rates		Average No. of Hours/Week	Hourly Rate	Total Weekly Rate
Name and Age of Child	Summer Season Rates		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? If yes, please explain.					<input type="checkbox"/> Yes <input type="checkbox"/> No
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 provide the agency name and amount contributed.					<input type="checkbox"/> Yes <input type="checkbox"/> No
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 _____		