STATE OF MICHIGAN
13th JUDICIAL CIRCUIT
ANTRIM, GRAND TRAVERSE & LEELANAU COUNTIES

FRIEND OF THE COURT CASE QUESTIONNAIRE
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CASE NO.

Attach your 4 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 2 federal tax returns, including all schedules. If self-employed, also attach a copy of your 3 most recent business tax returns and/or corporation returns.

Friend of the Court Address:
328 Washington Street, Ste 200, Traverse City MI 49684

Telephone No.
231-922-4660

Plaintiff name	Defendant name

GENERAL INFORMATION

Your full name	Date of birth	Place of birth: city & state

Address	City	State	Zip
Mailing Address (if different)	City	State	Zip

Social Security	Drivers License Number

Work Telephone	Home Telephone	Cell Telephone

Sex	Eye color	Hair color	Height	Weight	Race	Scars, tattoos, etc.

Are you a member of a Native American Tribe? ☐Yes ☐No If yes, which tribe? ______________________

Are you or the other parent In this case pregnant? ☐Yes ☐No If yes, complete a & b	a. When is the due date:	b. Are the parties in this case the biological parents of the expected child? ☐Yes ☐No

Names of all your dependent children	Birth date	Social Security No.	Sex	Address

School(s) and grade attended for each child Child Name	School	Grade	Expected Graduation Date

Do any of the children have physical or mental handicaps? ☐Yes ☐ No If yes, what?

Directions to the home where the minor children in this case reside:

Are you now, or have you ever been arrested, in prison or on probation? ☐Yes ☐No	Ever had a drug or alcohol problem? ☐ Yes ☐NO	Type of Drug	Any Treatments ☐Yes ☐ No	Date	Place of treatment

With whom are you presently living?

Do you have a mental or physical handicap That may limit your ability to work?
☐ Yes ☐No If yes, describe mental/physical condition.

Your father's full name	Your mother's full name

Your Brothers and Sisters:

Name:	Name:	Name:
Address:	Address:	Address:
Phone:	Phone:	Phone:

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EMPLOYMENT INFORMATION

CHECK YOUR INCOME TAX FILING STATUS:
☐ MARRIED ☐ SINGLE ☐ HEAD OF HOUSEHOLD NO. OF DEPENDANTS CLAIMED: _________

Your occupation	Your employer (if unemployed, name of last employer)			
Employer's address	City	State	Zip	Date hired
Gross earnings per pay period (earnings before taxes) $ ☐ Weekly ☐ Every other Week ☐ Twice/Month ☐ Monthly	Hourly pay rate(including shift premium and COLA) $	Total regular hours worked per pay period	Avg. overtime hours for past 12 months	
Second job - occupation	Employer			
Employer's address	City	State	Zip	Date Hired
Gross earnings per pay period (earnings before taxes) $ ☐ Weekly ☐ Every other Week ☐ Twice/Month ☐ Monthly	Hourly pay rate $	Total regular hours worked per pay period		

EDUCATIONAL BACKGROUND (check one)

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

WORK HISTORY – List last two jobs, including self-employment

Name of employer	Position Held	Dates Worked From To		
Employer's address	City	State	Zip	Hourly wage
Hours worked ☐Full time ☐Part time hours per week	Reason for leaving			
Name of employer	Position Held	Dates Worked From To		
Employer's address	City	State	Zip	Hourly Wage
Hours worked ☐Full time ☐Part time hours per week	Reason for leaving			

INCOME INFORMATION – List **Monthly** income from all sources

FIP/Grant $	Workers compensation $	Rental Property Income $	Commissions/Bonuses/Profit Sharing/Interest/Dividends $
Food Stamps $	Unemployment benefits $	V.A. Benefits $	Deferred Compensation/IRA $
Child Care Benefits $	Retirement/ Social Security benefits $	G.I. Benefits $	Trust Funds $
Social Security Disability (SSD) $	Sick Pay Benefits $	National Guard / Res. Drill Pay $	Pensions/Longevity/ Retirement $
Supplemental Security Income (SSI) $	Strike Pay/ SUB Pay $	Armed Services Paid Allowances $	Other Income/ Source:

Do any of the children 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)

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OTHER CASES IN WHICH YOU ARE INVOLVED

Do you have any other cases involving minor children? ☐ Yes, as payer ☐ Yes, as recipient ☐ No

If yes, complete sections below

No of children	Amount of order	Case No.	City, County & State

Do you pay or receive spousal support? ☐ Yes, as payer ☐ Yes, as recipient ☐ No If so, how much?

EXPENSES – per week or month

Rent/House Payment	$	Transportation	$
Food	$	Clothing	$
Heat	$	Insurance	$
Electricity	$	Entertainment	$
Telephone	$	Misc.	$

LIABILITIES

Total amount owed and to whom (home, car, credit cards, doctors, hospital, etc.). Amount of Weekly/monthly payments, who is paying:

To Whom Owed	Who's Paying	Total Owed	Payments	Per (wk/mo)
		$	$	
		$	$	
		$	$	
		$	$	
		$	$	

BANKRUPTCY INFORMATION

Have you ever claimed bankruptcy? ☐Yes ☐ No If yes, when: Chapter:

CHILD CARE INFORMATION

Do you have child care expenses for the minor children (under 12) in this domestic relations case during any time of the year? ☐ Yes ☐ No

If yes, please complete the child care verification form.

Check the reason(s) why you need childcare :

☐ Work related

☐ Looking for employment

☐ Enrolled in educational program to improve employment opportunities

If your reason for child care is educational related, provide the following information:

Name of educational institution	Total classroom hours per week.

HEALTH CARE INFORMATION – PLEASE PROVIDE A COPY OF THE CHILDREN'S HEALTH INSURANCE CARD	
Medical Insurance Company Name	
Dental Insurance Company Name	
Optical Insurance Company Name	
What dependant coverage is available to you without cost? ☐ Medical ☐ Dental ☐Optical	What is your cost per pay period for the following coverage ☐ Medical $_____ ☐ Dental $ _____ ☐Optical $ _____
Name of Policy Holder:_________________________	
How many people are covered by this insurance: _____	

INFORMATION REGARDING THE OTHER PARENT IN THIS CASE (if known)					
Full Name		Date of Birth		Place of Birth: City State	
Address City State Zip					Home telephone
Social Security Number	Drivers License Number		Work Telephone	Cell Telephone	Sex ☐ Male ☐Female
Eye Color	Hair Color	Height	Weight	Race	Scars, Tattoos, etc
Occupation	Name & Address of Employer				
Father's Full Name			Mother's Full Maiden Name		
Does your co-parent have other minor children? ☐Yes ☐No If so, how many? __________					

I hereby request child support services under the child support enforcement program of Title IV-D of the Social Security Act. I understand that any information provided to me or on my behalf is to be used only for the purpose of establishing paternity or securing child support.

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 attached your 4 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 income tax returns, including all schedules? If self-employed, also attach a copy of your 3 most recent business tax returns and/or corporation returns.

Have you enclosed a completed Child Care Verification form?

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS. RETURN THE ORIGINAL TO THE FRIEND OF THE COURT OFFICE.