

FRIEND OF THE COURT
Rena Topolewski



ASSISTANT FRIEND OF THE COURT
Edward V. Messing, Jr.

ST. CLAIR COUNTY FRIEND OF THE COURT
31st Judicial Circuit
201 McMorran Blvd., Room 1600
Port Huron, Michigan 48060
Phone (810) 985-2285
www.stclaircounty.org/offices/foc

Do not submit originals. Your documentation will not be returned to you. Any copies requested at the Friend of Court office will be assessed a copy fee.

REQUEST FOR INFORMATION

You must provide the following along with completing the attached:

- 4 Current paystubs and last years W-2 Forms (If self-employed or receive 1099s- last 3 years taxes)
- Childcare verification form completed, with attached pricelist from childcare provider, and signed by provider
- Complete name and address of employer(s)
- Proof of unemployment benefits
- Health insurance verification and cost (if any) verification for the children
- Other: _____

You must provide all information above prior to or at the time of the hearing. If the person requesting the hearing fails to appear for hearing or contact the office at the time of the hearing, their request may be dismissed. If either party fails to provide verification of employment, or income, an ability to earn may be imputed based on last known wage or an ability to earn a wage associated with their profession. A Show Cause hearing may be scheduled to compel release of information if either party fails to provide verification of any of the above information.

THE MICHIGAN CHILD SUPPORT FORMULA AND/OR SPOUSAL SUPPORT PROGNOSTICATOR WILL BE USED. IF SUPPORT IS CURRENTLY ORDERED, THIS MAY CAUSE A RAISE OR REDUCTION IN YOUR SUPPORT.

Case No: _____

Plaintiff's Name: _____ Attorney: _____

Defendant's Name: _____ Attorney: _____

If you are requesting Friend of the Court services, you must sign below.

I request child support services under the child support enforcement program of Title IV-D of the Social Security Act, by signing below.

I declare that the attached information is accurate and true to the best of my information, knowledge and belief.

Date: _____ Signature: _____

If you are not requesting Friend of Court Services, then you must opt out of Friend of the Court Services.



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HEALTH INSURANCE INFORMATION

Please verify current health insurance information for children on this case.

- Court Docket No:
- Client Name:
- Name of Children Insured:
- Policy Holder if other than client:
- Name of Employer:

Medical Insurance: _____ Claim Address: _____ City, State, Zip: _____ Phone No.: _____	Date Effective: _____	Policy No.: _____ Group No.: _____ Contract No.: _____
Optical Insurance: _____ Claim Address: _____ City, State, Zip: _____ Phone No.: _____	Date Effective: _____	Policy No.: _____ Group No.: _____ Contract No.: _____
Dental Insurance: _____ Claim Address: _____ City, State, Zip: _____ Phone No.: _____	Date Effective: _____	Policy No.: _____ Group No.: _____ Contract No.: _____
Prescription Insurance: _____ Claim Address: _____ City, State, Zip: _____ Phone No.: _____	Date Effective: _____	Policy No.: _____ Group No.: _____ Contract No.: _____
Other Insurance: _____ Claim Address: _____ City, State, Zip: _____ Phone No.: _____	Date Effective: _____	Policy No.: _____ Group No.: _____ Contract No.: _____

Completed by: _____ Phone: _____
Date: _____

Friend of the Court address
201 MCMORRAN BLVD., PORT HURON, MICHIGAN 48060

Telephone no
(810) 985-2285

Plaintiff name

V

Defendant name

GENERAL INFORMATION

1. Your full name (first, middle, & last)			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 license number		8. Work telephone	
9. Sex ___ M ___ F	10. Eye color	11. Hair color	12. Height	13. Weight	14. Race	15. Scars, tatoos, etc.	
16. Your father's full name				17. Your mother's full maiden name			
18. Names of all of your dependent children		Birthdate	Soc. Sec. No.		Address		
19. Are you or the other parent in this case pregnant? ___ Yes ___ No If yes, complete a. and b. below.							
a. When is the child due?			b. Are the parties in this case the biological parents of the expected child? ___ Yes ___ No				

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

20. Full name (first, middle, & last)			21. Date of birth		22. Place of birth: City and State		
23. Address			City		State	Zip	24. Home telephone
25. Social security number				26. Driver license number		27. Work telephone	
28. Sex	29. Eye color	30. Hair color	31. Height	32. Weight	33. Race	34. Scars, tatoos, etc.	
35. Father's full name				36. Mother's full maiden name			
37. Names of all the other parent's dependent children		Birthdate	Soc. Sec. No.		Address		

INCOME INFORMATION

38. Your occupation _____ 39. Your employer (if unemployed, name of last employer) _____

40. Employer's address _____ City _____ State _____ Zip _____ 41. Date hired _____

42. Gross earnings per pay period (earnings before taxes) \$ _____ weekly _____ bi-weekly _____ bi-monthly _____ monthly _____ 43. Social security number _____

44. Hourly pay rate (including shift premium and COLA) _____ 45. Total regular hours worked per pay period _____ 46. Avg. overtime hours for past 12 months _____

47. Second job _____ 48. Employer _____

49. Employer's address _____ City _____ State _____ ZIP _____ 50. Date hired _____

51. Gross earnings per pay period (earnings before taxes) \$ _____ weekly _____ bi-weekly _____ bi-monthly _____ monthly _____ 52. Hourly pay rate _____ 53. Avg. of hours worked per pay period since hire date _____

54. List MONTHLY income from all other sources, such as:

Commissions		Social Security Benefits	
Bonuses		V.A. Benefits	
Profit Sharing		Disability Insurance	
Interest		G.I. Benefits	
Dividends		Nat'l Guard & Res. Drill Pay	
Annuities		Armed Services	
Pensions/Longevity		Allowance for Rent	
Deferred Compensation/IRA		Rental Income	
Trust Funds		Spousal Support/Alimony	
Unemployment Benefits		General Assistance	
Strike Pay		AFDC	
SUB Pay		Supplemental Security Income SSI	
Sick Benefits		Other	
Workers Compensation			

55. Do you have any other alimony or child support order? No Yes, as payer Yes, as recipient If so, complete a. b. and c.

a. Amount of order (do not include arrearages) _____ b. Type of order/Case No _____ c. City, County and State _____

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 SSI	(check one) Dependent Benefit	Source of dependent benefit (Mother, Father, Stepparent)
*	*	*	*	*
*	*	*	*	*

58. 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 federal and state income tax returns.

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
Are you receiving financial assistance for child care from any federal or state agency: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state the name of the agency and the amount you 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 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? <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 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		

