

STATE OF MICHIGAN 34th Circuit Court Family Division Roscommon County	FRIEND OF THE COURT CASE QUESTIONNAIRE	CASE NO.
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Court Address Friend of the Court, 500 Lake Street, Roscommon, MI 48653 Family Division, Roscommon County Building, 500 Lake St., Roscommon, MI 48653		FAX no. 989-275-4584 989-275-8537	Court telephone no. 989-275-3121 989-275-5221
Caseworkers: Jennifer Councilman Holly Holm	email: councilmanj@roscommoncounty.net email: holmh@roscommoncounty.net		

Name:		Maiden Name:			
Residential address:					
Mailing address:			email:		
Sex:	Eye Color:	Hair Color:	Height:	Weight:	Race:
Birthdate:	Social Security No:		Driver's license no:		
Birth Place:		Home telephone:		Cell:	

LIST ALL YOUR CHILDREN 18 AND UNDER:

Name	Address	SS#	DOB	Child of Case	Overnights
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____	_____

EMPLOYER 1 INFORMATION: *(include your last 4 pay stubs/tax return)* Pay Period: Weekly Bi-Weekly Monthly 2x/month

Name: _____ Hire Date _____ Wage _____ Hours/week _____

Address: _____

Telephone: _____ Contact person: _____

EMPLOYER 2 INFORMATION: *(include your last 4 pay stubs/tax return)* Pay Period: Weekly Bi-Weekly Monthly 2x/month

Name: _____ Hire Date _____ Wage _____ Hours/week _____

Address: _____

Telephone: _____ Contact person: _____

OTHER SOURCES OF INCOME (monthly):

SSD: _____ Rental: _____ Housing: _____ Other: _____

SSI: _____ Military: _____ VA: _____

State Disability: _____ Social Security: _____ Unemployment: _____

SELF EMPLOYED: YOU MUST SUBMIT THE LAST 3 YEARS OF YOUR TAX RETURNS (BUSINESS AND PERSONAL). THIS INCLUDES ALL SCHEDULES AND ATTACHMENTS.

Tax Status: Single Joint Head of Household	Number of exemptions:
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PAY DEDUCTIONS:

Medical Insurance: _____	401k (mandatory): _____	City Tax/Name: _____
Dental Insurance: _____	401k (voluntary): _____	Union Dues: _____
Vision Insurance: _____	other retirement: _____	Other: _____

MEDICAL INSURANCE INFORMATION

Do **you** have insurance on the minor child(ren)? _____

If so, who is covered:

Name: _____ Relationship _____

Name of insurance company: _____

Address of insurance company: _____

Policy number: _____

Group number: _____

What does it cover: medical prescription dental optical

Is this insurance coverage through an employer: yes no

If so, name and address of employer: _____

Phone: _____ Contact person: _____

At what cost for family coverage? Monthly: _____

If insurance is provided by a third party (other than plaintiff and defendant; (i.e., current spouse)
please provide: name, date of birth and social security number

Name: _____ D/Birth _____ S.S.# _____

PLEASE PROVIDE THE FRONT AND BACK OF YOUR INSURANCE CARD

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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.					
Does a federal or state agency or a public or private entity contribute all or a portion of the cost of 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			