

OAKLAND COUNTY OAKLAND COUNTY FRIEND OF THE COURT
230 ELIZABETH LAKE ROAD
P. O. BOX 436012
PONTIAC MI 48343-6012

JOHN JAMES DOE JR
ATTN: INFORMATION
200 FULL ST
PONTIAC MI 48341-2759

Re: JANE DOE v JOHN DAVID DOE

Case No: 999999999



The Circuit Court
for the 6th Judicial Circuit of Michigan
Oakland County Friend of the Court
OAKLAND COUNTY, MICHIGAN

Oakland County Friend of the Court
230 Elizabeth Lake Road
P. O. Box 436012
Pontiac, MI 48343-6012

June 2, 2024

Court Case No: 2010-999999-DS
JOHN DOE v JANE J DOE

John James Doe JR
200 Full Street
Pontiac MI 48341-2759

RE: Notice of Support Review (2nd request)
Docket Number: 2010-999999-DS IV-D Number: 999999999

Dear John James Doe JR:

Please complete the enclosed forms and return them to our office with the following documents by June 16, 2024. **If you do not respond, it could mean a change to your order without your input.**

- Most recent tax returns, including any tax documents.
- **Four** most recent paycheck stubs from each source of income.
- Childcare verification form (if you are paying for childcare).
- Proof of unemployment, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and any other documents relating to the income you receive.
- Driver's license

Return all the information to:

Oakland County Friend of the Court
230 Elizabeth Lake Road
P. O. Box 436012
Pontiac, MI 48343-6012

Sincerely,

Ima Worker
Domestic Support Specialist

Enclosure(s)

STATE OF MICHIGAN 6th JUDICIAL CIRCUIT OAKLAND COUNTY	FRIEND OF THE COURT CASE QUESTIONNAIRE	CASE NO. and JUDGE 2010-999999-DS HON. JUDGE D JUDGE
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Oakland County Friend of the Court
230 Elizabeth Lake Road P. O. Box 436012 Pontiac, MI 48343-6012

Telephone:

Plaintiff Jane Jean Doe

v

Defendant John James Doe JR

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 [] M [] 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? [] Yes [] No	a. When is the child due?		b. Is the other party in this case the biological parent of the expected child? [] Yes [] No					24. Are you presently married? [] Yes [] 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) \$ [] weekly [] biweekly [] bimonthly [] monthly							30. Filing status _____ dependents claimed [] married [] single [] 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) \$ [] weekly [] biweekly [] bimonthly [] 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) \$ [] weekly [] biweekly [] bimonthly [] 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. [] 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)					
[] less than high school		[] High school graduate		[] Trade school graduate	
[] Associate's degree		[] Bachelor's degree		[] 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. <hr/> <hr/>
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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 no.		66. Professional license, type, and no.		67. Cell phone		68. E-mail address
69. Sex [] M [] F	70. Eye color		71. Hair color	72. Height	73. Weight	74. Race	75. Scars, tattoos, etc.	
76. Father's full name				77. Mother's full maiden name				
78. Names of other biological/adopted minor children he/she supports			Birthdate		Address			
79. Is this party pregnant? [] Yes [] No		a. When is the child due?		b. Is the party in this case the biological parent of the expected child? [] Yes [] No			80. Is this party married? [] Yes [] 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.			
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? [] Medical [] Dental [] Optical								
91. What dependent coverage is available by payment of an additional premium? (Specify cost per pay period.) [] Medical _____ per _____ [] Dental _____ per _____ [] 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 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 6th JUDICIAL CIRCUIT OAKLAND COUNTY	CHILD-CARE VERIFICATION	CASE NO. 2010-999999-DS HON. JUDGE D JUDGE
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Oakland County Friend of the Court
230 Elizabeth Lake Road P. O. Box 436012 Pontiac, MI 48343-6012

Telephone:

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. [] Yes [] 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. [] Yes [] 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		