

**The Circuit Court
for the 7th Judicial Circuit of Michigan
Support Modification Division
GENESEE COUNTY, MICHIGAN**

**Support Modification Unit
630 S. Saginaw St., Ste. 2500
Flint, MI 48502**

Phone: (810) 257-3300

This paperwork should be filled out if you want your child support order to be changed by the Friend of the Court. By law, the Friend of the Court will review child support orders when there is a change in circumstances. By filling out this form, you are telling the Friend of the Court to review your child support order and that you believe there has been a change of circumstances since your last order was entered.

CASE NUMBERS: _____

PAYER'S NAME: _____ PAYEE'S NAME: _____

PHONE NO.: _____ PHONE NO.: _____

STREET ADDRESS: _____ STREET ADDRESS: _____

CITY, STATE, ZIP: _____ CITY, STATE, ZIP: _____

MODIFICATION REVIEW REQUEST

The reason I think there has been a change since the last order is because (check all that apply):

- My income has changed.
- The income for the other parent has changed.
- It has been more than 3 years since my order has been changed.
- An order has been entered changing the custody, placement, or parenting time of the child(ren) on this case.
- There has been a change in the child care costs for the child(ren) on this case
- There has been a change in the number of children I care for.
- There has been a change in the number of children the other party cares for.
- There has been a change in my health care coverage for the child(ren).
- There has been a change in the other parent's health care coverage for the child(ren).
- I have been released from incarceration.
- The other party has been released from Incarceration.

PLEASE ATTACH ANY PAPERWORK THAT SUPPORTS THE BOXES YOU CHECKED.

PART ONE

Please answer these few questions so we can be sure you are the person filling out the form.

Your full name		Your date of birth	E-mail Address			
Address (Street, City, State, Zip Code)						
Home Phone	Work Phone	Cell Phone	Social Security #	Driver's License #		
Scars, Tattoos			Eye Color	Hair Color	Race	Gender

PART TWO

CHILDREN'S INFORMATION

Now we need to gather some basic information about your children and your income so we can calculate support under the Michigan Child Support Formula. The more information you provide the better our calculation can be.

Names of children in common with other parent on this case	Birthdate	SSN	Anticipated Graduation Date	Lives with (if not you or other parent on this case, provide name and address)
				<input type="checkbox"/> Me <input type="checkbox"/> Other parent <input type="checkbox"/> Someone else
				<input type="checkbox"/> Me <input type="checkbox"/> Other parent <input type="checkbox"/> Someone else
				<input type="checkbox"/> Me <input type="checkbox"/> Other parent <input type="checkbox"/> Someone else
				<input type="checkbox"/> Me <input type="checkbox"/> Other parent <input type="checkbox"/> Someone else

How many over nights do you have your children per year? _____

****If you have more children you cannot fit on this part of the form, attach a sheet of paper and list the same information about your other children.****

Names of other biological or adopted (or guardianship) minor children you support	Birthdate	Lives with (if not you or other parent on this case, provide name and address)
		<input type="checkbox"/> Me <input type="checkbox"/> Other parent <input type="checkbox"/> Someone else
		<input type="checkbox"/> Me <input type="checkbox"/> Other parent <input type="checkbox"/> Someone else

****If you have more children you cannot fit on this part of the form or if you are currently pregnant, attach a sheet of paper and list the same information about your other children.****

THIS BOX IS FOR IF YOU ARE CURRENTLY EMPLOYED

Your occupation	Your current employer	Date Hired
Employer's Address		Employer's Phone #
Earnings before taxes \$ <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice per month <input type="checkbox"/> Monthly	Hourly pay rate	Avg hours worked per pay period
<input type="checkbox"/> Self Employed – Please provide 3 Years Tax Returns		
Currently Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, provide documentation (Medical or Social Security verification)		

IF YOU HAVE MORE THAN ONE JOB, ATTACH A SHEET OF PAPER WITH THE SAME INFO ABOUT THE OTHER JOBS.

THIS BOX IS FOR IF YOU ARE CURRENTLY UNEMPLOYED

Name of last full time employer	Position or job title at last employer	Last day of employment
Employer's Address		Employer's Phone #
Earnings before taxes \$ <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice per month <input type="checkbox"/> Monthly	Hourly pay rate	Avg hours worked per pay period
Length of time employed in last full time position	Reason for leaving last full time position	

PART THREE**REQUIRED INFORMATION PURSUANT TO THE FORMULA****OTHER INCOME, ASSETS, AND BENEFITS**

Commissions	Unemp. Benefits	Nat'l Guard & Res Drill Pay	
Bonuses	Armed Services	Allowance for Rent	
Profit Sharing	Sick Benefits	Rental Income	
Dividends	Worker's Comp	State Disability Asst.	
Annuities	Soc. Sec. Benefits	VA Benefits	
Pensions	Disability Insurance	SSI	
Trust Funds	GI Benefits	Other	
Alimony or Spousal Support involving another person not a parent to this case		<input type="checkbox"/> No <input type="checkbox"/> Yes, as payer <input type="checkbox"/> Yes, as recipient	
Case Number	County, State	Amount	
Case Number	County, State	Amount	
Do any of the children listed above receive payments from the Social Security Administration? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Child's Name	Monthly Amount	Type of Benefit	Source of Dependent Benefit (mother, father, stepparent, self)
		<input type="checkbox"/> SSI <input type="checkbox"/> Dependent Benefit	
		<input type="checkbox"/> SSI <input type="checkbox"/> Dependent Benefit	

PERSONAL HISTORY

What is your educational background? (Check all that apply)	
<input type="checkbox"/> Less than high school	<input type="checkbox"/> Associate's degree (specify):
<input type="checkbox"/> High school graduate	<input type="checkbox"/> Bachelor's degree (specify):
<input type="checkbox"/> Trade school graduate (specify):	<input type="checkbox"/> Graduate degree (specify):
Do you have any professional licenses? List:	
Are you able to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why? Please provide documentation	Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what dates:

PART FOUR

MEDICAL COVERAGE			
How do you get your medical insurance? <input type="checkbox"/> Employer Provided <input type="checkbox"/> Medicaid/Medicare <input type="checkbox"/> No Insurance <input type="checkbox"/> Spouse			
Medical insurance company name, address, telephone #, policy number, beginning date			
Dental insurance company name, address, telephone #, policy number, beginning date			
Optical insurance company name, address, telephone #, policy number, beginning date			
What dependent coverage is available to you without additional cost? <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Optical			
What dependent coverage is available you with additional cost? How much more than individual coverage? (Specify pay period)			
<input type="checkbox"/> Medical per <input type="checkbox"/> Dental per <input type="checkbox"/> Optical per			
Who do you, or your current spouse, cover on your insurance?			
Name	Birthdate	Relationship	Type

IF YOU HAVE ANY ADDITIONAL INFORMATION, PLEASE PROVIDE.

PART FIVE: VERY IMPORTANT

- **IF YOU HAVE INFORMATION ABOUT THE OTHER PARTY PLEASE COMPLETE THE FOLLOWING PAGE.**
- **IF YOU HAVE DAY CARE COMPLETE A CHILD CARE VERIFICATION FORM.**

7 TH JUDICIAL CIRCUIT OF MICHIGAN, GENESEE COUNTY	FRIEND OF THE COURT CHILD SUPPORT QUESTIONNAIRE OTHER PARTY INFORMATION	CASE NUMBER
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630 S. SAGINAW STREET, SUITE 2500, Flint, MI 48502

810.257.3300

INFORMATION REGARDING THE OTHER PARENT ON THIS CASE.

PERSONAL INFORMATION							
Full name			Date of birth	Address			
Home Phone	Work Phone	Cell Phone	Social Security #	E-mail Address			
Scars, Tattoos			Driver's License #	Eye Color	Hair Color	Race	Gender

OTHER CHILDREN'S INFORMATION		
Names of other biological or adopted minor children the other parent supports	Birthdate	Lives with (if not the other parent on this case, provide name and address)
		<input type="checkbox"/> Other parent <input type="checkbox"/> Someone else
		<input type="checkbox"/> Other parent <input type="checkbox"/> Someone else

INCOME INFORMATION		
Occupation	Employer	Position Title
Employer's Address		Employer's Phone #
Earnings before taxes	Hourly pay rate	Avg hours worked per pay period
\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice per month <input type="checkbox"/> Monthly If you do not know the specific information, how much do you think the person earns and why?		

MEDICAL COVERAGE			
Does the other party, or their spouse provide health insurance for the child(ren) in common? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know			
What type of coverage does the other party, or their spouse, provide? <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Optical			
Who does the other party, or their current spouse, cover on their insurance?			
Name	Birthdate	Relationship	Type

7 TH JUDICIAL CIRCUIT OF MICHIGAN GENESEE COUNTY	FRIEND OF THE COURT CHILD CARE VERIFICATION	CASE NUMBER
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630 S. SAGINAW STREET, SUITE 2500, FLINT, MI 48502

810.257.3300

Complete the top section of this form and have your child care provider complete the lower section. **Please remember to return the completed form to the Friend of the Court.**

PARENT SECTION	
Full name	
Name and Ages of children involved in this case	
Check the reason why you need child care: <input type="checkbox"/> Work Related <input type="checkbox"/> Looking for employment <input type="checkbox"/> Enrolled in educational program to improve employment opportunities	

FOR CHILD CARE PROVIDER USE ONLY

Name of Provider		Address			Phone Number	
Name and Age of Child		School Year Rates	Average Number of Hours/Week	Hourly Rate	Total Weekly Rate	
Name and Age of Child		Summer Season Rates	Average Number 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/Title			

REMINDER CHECKLIST

- Have you signed this questionnaire?
- Have you completed the number of overnights you have your child annually?
- 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, & 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.
- If you are asking for reimbursement of child-care expenses, have you completed and attached the Child Care Verification form?
- Make a copy of these forms for your own records.
- Send the original completed and signed form to the Friend of the Court.
Mail to 630 S. Saginaw Street, Suite 2500, Flint, MI 48502 or email to focinfo@co.genesees.mi.us

By signing here, you are declaring that the information in this questionnaire and any attachments are true to the best of your information, knowledge, and belief.

By signing here, you are requesting child support services pursuant to the child support enforcement program of Title IV-D of the Social Security Act.



Signature

DATE: _____

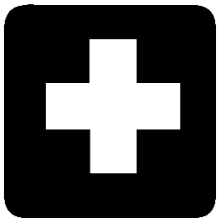
****IF THERE IS NO SIGNATURE, WE CANNOT USE THIS INFORMATION****

FOC MODIFICATION FAQS



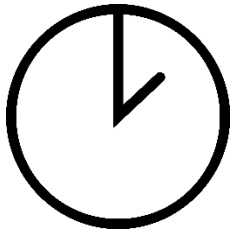
Why am I getting this packet? Per MI Law, the FOC must review child support orders and make changes every three years if there is public assistance and more often if there is a change in income, health insurance, or where the child lives. Sometimes the FOC must change an order when required provisions were not included in the most recent order.

Why do you need my income information and tax returns? The FOC is required to use the child support formula, which uses both parties' incomes and deductions. We cannot use monthly budgets or spouses' incomes, only the two parents' incomes can be used.



If I provide health insurance, why do I need ordinary medical? Ordinary medical is different than health insurance. Child support orders address health insurance, but they also address ordinary medical. Ordinary medical is required in all support orders to address both parents' out of pocket medical costs.

I have other children, can you consider that? Yes, we can consider other minor children you care for. The FOC cannot add new children to a support order.



How long will this take? Per MI law, we have up to 6 months to complete a modification, but we try to complete all of our modifications in less than 4 months.

What if the other party is not using their parenting time? Per the child support formula, unless the parties agree, the FOC must follow the last court order on parenting time. If you want to change the parenting time order, we have parenting time caseworkers who may be able to help. We also have motion packets to go before a judge or referee to address this issue.