



**The Circuit Court
for the 37th Judicial Circuit of Michigan
Friend of the Court
CALHOUN COUNTY, MICHIGAN**

**Friend of the Court
161 East Michigan Avenue
Battle Creek, MI 49014**

**Phone: (269) 969-6500
Fax: (269) 969-6564**

May 13, 2013

Court Case No: 2000000000-DP
POE MARGARET A v POE EDGAR A

Margaret Ann Poe
63 Armwong Ct
Ypsi, MI 48888

**RE: Notice of Support Review (2nd request)
Docket Number: 2000000000-DP IV-D Number: 999999999**

Dear Ms. Poe:

Please complete and return the enclosed forms within fourteen (14) days. A party who fails to provide information may receive an unfavorable result.

All information should be returned to:

Friend of the Court
161 East Michigan Avenue
Battle Creek, MI 49014

Sincerely,

Lara Mow
Office Assistant

Enclosure(s)

Friend of the Court 161 East Michigan Avenue Battle Creek, MI 49014	Telephone: (269) 969-6500 Fax: (269) 969-6564
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Plaintiff Poe Margaret A	v	Defendant Poe Edgar A
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Complete this form and sign on page 4.

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. Names of children in common with other parent in this case				Birthdate	Gender	Soc. sec. no.	Address	No. of overnights you have w/ child annually				
22. Names of all additional 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			
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											

YOUR INCOME, MEDICAL, EDUCATIONAL, AND HEALTH INSURANCE INFORMATION(continued)

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 _____	Worker's 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 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)		Source of dependent benefit (mother, father, stepparent)
		SSI	Dependent benefit	

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

48. Medical insurance company name, address, telephone no.	Policy number	Beginning date, if known
49. Dental insurance company name, address, telephone no.	Policy number	Beginning date, if known
50. Optical insurance company name, address, telephone no.	Policy number	Beginning date, if known

51. What dependent coverage is available to you without cost? Medical Dental Optical

52. What dependent coverage is available by payment of an additional premium? (Specify cost per pay period.)
 Medical _____ per _____ Dental _____ per _____ Optical _____ per _____

53. Individuals currently covered by your insurance

Name	Birthdate	Relationship	Medical(X)	Dental(X)	Optical(X)

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? Yes 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

55. Check the reason(s) which explain why you need child care and estimate the number of hours child care is received for each.

Reason

Estimated number of hours per week

Work related

Looking for employment

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

YOUR ADDITIONAL INFORMATION

57. List any additional information that would be useful to the court in making a support recommendation.

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 number

66. Professional license, type, and no.

67. Cell phone

68. E-mail address

69. Sex

70. Eye color

71. Hair color

72. Height

73. Weight

74. Race

75. Scars, tattoos, etc.

M F

76. Father's full name

77. Mother's full maiden name

78. Names of all additional minor children he/she supports

Birthdate

Address

79. Is this party pregnant?

a. When is the child due?

b. Is the party in this case the biological parent of the expected child?

80. Is this parent married?

Yes No

Yes No

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

INFORMATION REGARDING THE OTHER PARENT IN THIS CASE(continued)

87. Medical insurance company name, address, telephone no. Policy number Beginning date, if known

88. Dental insurance company name, address, telephone no. Policy number Beginning date, if known

89. Optical insurance company name, address, telephone no. Policy 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(X)	Dental(X)	Optical(X)
_____	_____	_____			
_____	_____	_____			
_____	_____	_____			
_____	_____	_____			

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.

_____ Date

_____ Signature

Reminder List:

- Have you signed this questionnaire?
- 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.

Friend of the Court
161 East Michigan Avenue Battle Creek, MI 49014

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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 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 above named child(ren).

Name of provider		Address			
City	State	Zip	Country	Area Code and Telephone no.	
Name and age of Child	School Year Rates		Avg. No of Hours/Week	Hourly Rate	Total Weekly Rate
Name and age of Child	Summer Season Rates		Avg. 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 above information 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 above information is true, accurate, and complete.					
Date _____		Signature and title of provider _____			