

# RESPONSE TO MOTION TO CHANGE SUPPORT ORDER

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The other party to your court case has requested a change in the child support order, as stated in the Motion to Change Support Order attached to this. You may wish to respond to the motion. If so, complete and return the Response to Motion to Change Support Order and the form entitled Child Support Recommendation Questionnaire attached to this notice. Your response will not be considered complete without the questionnaire.

THESE FORMS SHOULD BE COMPLETED AND RETURNED TO THE FRIEND OF THE COURT OFFICE WITHIN 21 DAYS OF THE DATE THEY ARE MAILED TO YOU. When you return the forms, or after 21 days, whichever occurs first, the review staff will review the Friend of the Court file and the materials filed by both parties. If there is not enough information, more information will be requested, researched to find through reports available to FOC, imputed based on available evidence, or the matter may be set for a hearing.

If an initial recommendation is issued and no objections are filed within 21 days after it is mailed, a court order will be entered adopting the initial recommendation, and the modification will be complete.

If you or the other party disagree with the initial recommendation, you may file Objections to the Initial Recommendation. If objections are filed, the matter will be set for hearing before the Judge/Referee. At the hearing, you will be given an opportunity to present evidence regarding the needs of your children, your income, and the other party's income. You may represent yourself at this hearing or you may hire an attorney to represent you. The FOC cannot give you legal advice and does not conduct a support investigation for this hearing. **The FOC does not represent either party at this hearing. No attorney is provided for either party. YOU ARE RESPONSIBLE FOR PREPARING YOUR CASE FOR THE HEARING.**



## CHILD SUPPORT FINANCIAL QUESTIONNAIRE

Case No.		Date:	
Your Name:		Phone No.	
Address:			
Other Party's Name:		Other Party's Phone No.	
Other Party's Address:			
Children in common with other parent	Birthdate	SSN	Current grade level
Names of other biological/adopted minor children you support	Birthdate	With whom does the child reside	Is there child support? If so what county?
Are you pregnant? [ ] Yes [ ] No	When is the child due?	Is the other party the biological parent? [ ] Yes [ ] No	Are you presently married? [ ] Yes [ ] No
<b>Employment Information</b>			
Your Occupation		Your employer	
Employer's address	City	State	Zip
			Date hired
Gross earnings per pay period (earnings before taxes) \$ [ ] weekly [ ] biweekly [ ] bimonthly [ ] monthly [ ] annually		Hourly Pay rate	Average hours worked per pay period
Second Job		Employer	
Employer's address	City	State	Zip
			Date hired
Gross earnings per pay period (earnings before taxes) \$ [ ] weekly [ ] biweekly [ ] bimonthly [ ] monthly [ ] annually		Hourly Pay rate	Average hours worked per pay period
<b>If unemployed and not receiving unemployment benefits, or working part-time only, provide the following information:</b>			
Name of last full-time employer		Address of last full-time employer	
Position held at last place of full-time employment		Last date 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 [ ] monthly [ ] bimonthly [ ] monthly			

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**YOUR FINANCIAL INFORMATION**

**ATTACH A COPY OF YOUR MOST RECENT TAX RETURNS AND W-2 FORMS, YOUR LAST FOUR PAY STUBS, AND OTHER VERIFYING INFORMATION SUCH AS SOCIAL SECURITY STATEMENT, ROYALTIES, PENSIONS, ETC. WITH THIS FORM**

What is your filing status on your taxes?    Single ☐    Married ☐    Head of Household ☐

How many dependency exemptions do you claim?

Gross Income (before taxes)	Amount	Rate of Pay (please check one)				
		Weekly	Bi-week	Semi-Mo	Monthly	Annual
Salary/Wage (Included COLA/Shift Prem)						
Overtime						
Second Job						
Commissions						
Bonuses/Profit Sharing						
Interest/Dividends						
Annuities/Trust Funds						
Pensions/Longevity						
Deferred Comp/IRA						
Unemployment Benefits						
Strike Pay						
Worker's Compensation						
Social Security Benefits						
Disability Insurance						
GI Benefits						
Veteran's Benefits						
Armed Services/National Guard						
Allowance for Rent						
Rental Income						
Alimony and other Spousal Support						
Supplemental Security Income SSI						
Other: _____						

**Do any of the children under your care receive payments from the Social Security Administration?**

Child's Name	Amount (monthly)	Type of Benefit (check one)		Source of dependent benefit (mother, father, stepparent)
		SSI	Dependent benefit	

**Attach your four most recent paycheck stubs, a copy of your last federal and state income tax returns including all schedules and W-2s. If self-employed, also attach a copy of your three most recent business tax returns and/or corporation returns.**

Do you have any medical conditions/restrictions that affect your ability to work? ☐ yes ☐ no

If yes, please explain your medical condition/restriction: (please provide valid documentation for diagnosis)

What is your educational background? (check one)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Less than high school | <input type="checkbox"/> High school graduate | <input type="checkbox"/> Trade school graduate |
| <input type="checkbox"/> Associate's degree    | <input type="checkbox"/> Bachelor's degree    | <input type="checkbox"/> Graduate degree       |

CHILD SUPPORT FINANCIAL QUESTIONNAIRE – PAGE 3

## YOUR FINANCIAL INFORMATION (continued)

Expenses	Amount	Rate of Deduction (please check one)				
		Weekly	Bi-week	Semi-Mo	Monthly	Annual
Alimony and Spousal Support						
Union Dues						
Other Mandatory withholding*						
Term Equivalent Insurance Premium (if child is the beneficiary)						

\* Please explain the withholding:

## HEALTH CARE INFORMATION

Insurance company name, address, phone	Policy/Group Number	Beginning date, if known
Medical		
Dental		
Optical		

What dependent coverage is available to you without costs? ☐ Medical ☐ Dental ☐ Optical

What dependent coverage is available by payment of an additional premium? (specify cost per pay period)

[ ] Medical \$\_\_\_\_\_ per \_\_\_\_\_ [ ] Dental \$\_\_\_\_\_ per \_\_\_\_\_ [ ] Optical \$\_\_\_\_\_ per \_\_\_\_\_

Individuals currently covered by your insurance

Name	Birth Date	Relationship	Medical	Dental	Optical

## CHILD CARE INFORMATION

Are there work related child care costs for the children on this case?

[ ] Yes [ ] No If yes, how much per week? \$ \_\_\_\_\_ How many weeks per year? \_\_\_\_\_

**BEFORE THE CHILD CARE EXPENSES CAN BE CONSIDERED, VERIFICATION IS NEEDED. A CHILD CARE VERIFICATION FORM IS ATTACHED WITH THIS MOTION, IT MUST BE FILLED OUT AND SIGNED BY PROVIDER.**

ADDITIONAL COMMENTS

I DECLARE UNDER PENALTIES OF PERJURY THAT THE STATEMENTS ABOVE AND ON THE PRECEEDING PAGES ARE TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**STATE OF MICHIGAN**  
26TH JUDICIAL CIRCUIT  
ALPENA COUNTY

**CHILD-CARE VERIFICATION****CASE NO.**

Friend of the court address

Telephone no.

719 W CHISHOLM ST ALPENA MI 49707

(989)354-9710

**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 ☐ NoDoes 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