Muskegon County 14th Circuit Court- Family Division

Instructions for Filing a MOTION TO REVIEW CHILD SUPPORT

Please read all instructions carefully. Accuracy and completeness are important. Court staff cannot provide legal advice.

Use this Motion if:

- You have a pending divorce, separate maintenance, paternity, or family support case and you want the Court to change support;
- You have a final Judgment of Divorce, separate maintenance, paternity order or a family support case but child support was not included; or
- You already have a current child support order in your Judgment of Divorce, separate maintenance, paternity order, or order of family support and you want the Court to review child support using the Michigan Child Support Formula.

Note: Please be advised that filing this motion may result in a decrease or increase in your child support depending on application of the Michigan Child Support Formula.

WARNING: Parties that Opted Out of Friend of the Court Services cannot file this motion. Separate forms must be filled out to open a Friend of the Court Case. Please contact 1-877-543-2660 for more information.

Instructions for Filing a Motion to Review Child Support

1. Complete the top portion of the attached Motion to Review Child Support. In paragraph #2, you must state the reason why you are requesting a child support review. Sign and date your Motion.
2. Bring your completed Motion to the Circuit Court Records office to file. They are located at the Muskegon Hall of Justice at 990 Terrace Street, Suite 600, Muskegon MI 49442.
3. There is a $60 filing fee. If you cannot afford the filing fee, ask the clerk for a Fee Waiver Request (Form MC 20).
4. If desired, make a copy for your records before filing.

What Happens next?

- Court staff will schedule a hearing regarding your Motion to Review Child Support with a Family Court Referee and will send the parties notice of this hearing.

- If the person who filed the motion fails to appear, the motion will be dismissed.

- If you have an email on file with the Friend of the Court, hearing notices and documents WILL be emailed to you. If you prefer to receive documents via first class mail, you must fill out and submit the **Request to Discontinue E-Service** form found on our website or at the Muskegon Family Court office.

STATE OF MICHIGAN 14th JUDICIAL CIRCUIT MUSKEGON COUNTY	**MOTION TO REVIEW CHILD SUPPORT**	**FILE NO.**

990 Terrace Street, Ste. 600 Muskegon, MI 49442 (231) 724-6421

Plaintiff's information:

Name:
Address:
City, State, Zip:
Telephone #:

Defendant's information:

Name:
Address:
City, State, Zip:
Telephone #:

INCOME INFORMATION

Plaintiff's Information:

Employer:
Address:
City, State, Zip:
Telephone #:

Defendant's Information:

Employer:
Address:
City, State, Zip:
Telephone #:

1. I am requesting that the Court review my current child support order or establish a child support order, including child care, medical obligation and if applicable, arrearage payment using the Michigan Child Support Formula.
2. Conditions regarding support have changed as follows: (if necessary attach a separate sheet)

3. I understand that by requesting a review, my child support, child care, medical obligation or arrearage payment may increase or decrease depending on the parties' current income information.

I declare that the above statements are true to the best of my knowledge and belief.

_____ _____

Date Signature of party filing motion

INSTRUCTIONS FOR FILING FOC QUESTIONNAIRE AND FINANCIAL PROOFS FOR A MOTION TO REVIEW CHILD SUPPORT

In order for the Muskegon County Family Court to process your Motion to Review Child Support, you must complete the following:

1. Complete the "Support Questionnaire" and attach the following:

    a. If employed: attach copies of your last two (2) recent pay stubs, your W2 from last year and copies of your last two (2) years of tax returns.

    b. If you are self-employed: attach copies of your last three (3) years of individual and business tax returns including all schedules and forms.

    c. If you are not employed: attach proof of your unemployment benefits, proof of income from your last employment, your W2 from last year and copies of your last two (2) years of tax returns.

    d. If you are disabled: attached proof of your disability benefits or worker's compensation benefits, a recent statement from your treating physician noting your work restrictions and/or a recent statement from your treating physician stating you are unable to work due to your medical condition (if applicable), your W2 from last year and copies of your last two (2) years of tax returns.

    Note: Your motion will be returned to you if you fail to complete the support questionnaire and provide all requested documentation.

2. If you have child care expenses you must attach the "Child Care Verification" form. This form must be completed and signed by your childcare provider.

3. These financial forms should be mailed or turned in to: Muskegon County Friend of the Court, 990 Terrace Street, Ste. 300, Muskegon, MI 49442. You may also email them to: imaging@muskegoncounty.net

To the Clerk: For FOC office

STATE OF MICHIGAN 14th JUDICIAL CIRCUIT MUSKEGON COUNTY	FRIEND OF THE COURT CASE QUESTIONNAIRE	CASE NO. and JUDGE

Friend of the court address | **Telephone no.**

990 Terrace Street, Ste 300, Muskegon, MI, 49442 | (231)724-6421

Plaintiff	v	Defendant

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 earings 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	Type of benefit (check one) 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?
☐ 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 ( )	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? ☐ 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.

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.

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

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.

Case No. _____

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 two 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 14th JUDICIAL CIRCUIT MUSKEGON COUNTY	CHILD-CARE VERIFICATION	CASE NO. and JUDGE

Friend of the court address
990 Terrace Street, Ste 300, Muskegon, MI, 49442

Telephone no.
(231)724-6421

PARENT INFORMATION

Complete first page of this form and have your child-care provider complete page 2.
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 page 2 of this form for the child(ren) named above.

Case No. _____

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? Yes ☐ 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? Yes 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