

ST. JOSEPH COUNTY FRIEND OF THE COURT

Address: PO Box 249, Centreville MI, 49032

Phone: (269) 467-5570

Fax: (269) 467-5579

REQUEST FOR CONSENT ORDER TO CHANGE CHILD SUPPORT, MEDICAL INSURANCE, OR CHILD CARE

NOTE: The Friend of the Court reserves the right to reject this agreement, if necessary. If an attorney represents either party, the attorney must prepare any Consent Order. Both parties must review this form before submitting.

Court Order Number: _____

Plaintiff's Name, DOB, SS#, Address, Phone #.

Defendant's Name, DOB, SS#, Address, Phone #.

Minor child(ren):

Full Name: _____

DOB: _____

SSN: _____

Full Name: _____

DOB: _____

SSN: _____

Full Name: _____

DOB: _____

SSN: _____

THIS BOX MUST BE COMPLETED OR THE ORDER WILL NOT BE DRAFTED
Are you receiving any of the following forms of public assistance: (check all boxes that apply).
() grant monies/TANF () child care assistance () Medicaid () not receiving any

IF THE CUSTODIAL PARENT IS RECEIVING ANY FORM OF PUBLIC ASSISTANCE, THEN THE PARTIES CANNOT USE THIS FORM TO CHANGE CHILD SUPPORT

CHILD SUPPORT AND CHILD CARE:

Do you want the Friend of the Court to determine the Child Support an/or Child Care amount? ___YES ___NO

The new child support amount: \$ _____ per month per child for _____ child(ren) for a total of \$ _____

The new ordinary medical amount: \$ _____ per month per child for _____ child(ren) for a total of \$ _____

The new child care amount: \$ _____ per month per child for _____ child(ren) for a total of \$ _____

of overnights with Plaintiff _____; # of overnights with Defendant _____

When will this new amount begin? _____ (Must be the 1st day of any given month)

Do you wish to forgive arrears? Child Support Arrears ___YES ___NO
Child Care Arrears ___YES ___NO

If you are agreeing on an amount other than what the Michigan Child Support Formula states, you must state the reason why: _____

PLAINTIFF'S EMPLOYER: _____
(name, address and telephone)

DEFENDANT'S EMPLOYER: _____
(name, address and telephone)

MEDICAL INSURANCE:

Who is responsible for health care insurance? ___DAD ___MOM ___BOTH

What percentage of uninsured health care expenses will be paid by DAD ___% MOM ___%

COURT COSTS: (PLEASE PAY BY MONEY ORDER ONLY; PAYABLE TO: FRIEND OF THE COURT)
THE COST TO PREPARE THE ORDER IS \$35 AND MUST BE SENT WITH THIS FORM.

I HEREBY DECLARE THE ABOVE TO BE TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

DATE: _____ PLAINTIFF'S SIGNATURE: _____

DATE: _____ DEFENDANT'S SIGNATURE: _____

INSTRUCTIONS FOR COMPLETING A REQUEST FOR CONSENT ORDER TO CHANGE
CHILD SUPPORT, CHILD CARE, OR MEDICAL INSURANCE

**IF THE PARTY HAVING CUSTODY OF THE CHILD(REN) IS ON PUBLIC/STATE ASSISTANCE,
(FIP,FOOD STAMPS, MEDICAID) YOU MAY NOT CHANGE SUPPORT**

THIS FORM IS TO ASK THE FRIEND OF THE COURT (FOC) TO PREPARE AN ORDER TO CHANGE A CURRENT ORDER. **Please complete all sections that apply.**

GENERAL INFORMATION: This information is necessary to complete the consent order. It must be provided.

CHILD SUPPORT: If the parent having custody of the child(ren) **is not** receiving any form of public assistance, the parties may agree upon the amount of support with the understanding that the child(ren) is/are entitled to the amount recommended by the Michigan Child Support Formula and that the parent having custody is able to meet the needs of the child(ren) with the agreed upon amount. **If you wish to stop child support you must contact the FOC to make sure you can consent to this or if you have to petition.** If this section is left blank, the FOC will insert the amount pursuant to the last order of support. If you are deviating from the Formula, you must state the reason why.

CHILD CARE: If the parent who has custody of the child(ren) **is not** receiving any form of public assistance and is currently paying for child care, the parties may agree to an amount of child care for the non-custodial parent to pay. The parties may also ask the FOC to conduct an investigation and recommendation pursuant to the Michigan Formula to determine a child care amount. Child care shall continue until the start of the school year immediately following the 12th birthday of the child. If child care is discontinued prior to the child's 12th birthday, it is the responsibility of the parent having custody to notify the FOC in writing and the child care charge will stop.

MEDICAL INSURANCE: Who will be responsible for providing the insurance of the minor child(ren)? If neither party is listed, the order will state: "Both parties shall obtain and maintain health care coverage that is available at a reasonable cost."

COURT COSTS: Who will pay for the court costs for this change? The cost is \$35.00 payable by money order. Please make payable to: Friend of the Court. This fee must be paid prior to preparation of the consent order and it is **nonrefundable**.

NOTICE

**AFTER THIS FORM IS SUBMITTED WITH THE \$35 FEE, THE F.O.C. WILL PREPARE
THE ORDER TO BE SENT TO EACH PARTY FOR SIGNATURE. BOTH PARTIES MUST
SIGN THE ORDER BEFORE THE JUDGE WILL APPROVE**

FOR QUESTIONS OR APPOINTMENTS CALL (269)467-5570