FAMILY LAW SOLUTIONS PLLC

Third-Party Custody Questionnaire

So that we will be able to answer your questions and handle your case in a prompt and efficient manner, it is important that you attempt to answer the following questions fully and accurately. If you need additional space for an answer, you may use the back of a page. The completed questionnaire will be kept confidential and will remain in our possession. Please print.

Date:_____ Referred by:_____

PETITIONER A CURRENT PERSONAL INFORMATION:

Full Name_____

All previous names you have ever used_____

Present Street Address_____

City_____ County_____ State_____ Zip_____

ADDRESS FOR MAIL IF DIFFERENT THAN HOME ADDRESS_____

Home Phone_____ Business Phone_____

Email_____ Cell Phone_____

Social Security Number_____

Length of Residence in Minnesota_____

Birthplace_____ Birthdate_____ Age_____

Religion_____ Race_____

Highest Level of Education_____ Year Completed_____

Present Health_____

Physician or Clinic_____

Are you presently in the military service?_____

PETITIONER A EMPLOYMENT INFORMATION (provide a current paycheck stub):

Employer_____

Address_____

Occupation_____

Length of Time with this Employer_____

How often are you regularly paid:

Weekly_____ Every two weeks_____ Twice per month_____ Monthly_____

ATTACH A CURRENT PAYCHECK STUB

Do you receive, or expect to receive, any of the following as income:

Public Assistance	☐ Yes ☐ No
Social Security Benefits for Yourself	☐ Yes ☐ No
Social Security Benefits for Child(ren)	☐ Yes ☐ No
Unemployment Compensation	☐ Yes ☐ No
Worker's Compensation	☐ Yes ☐ No
Rental Income	☐ Yes ☐ No
Other Income	☐ Yes ☐ No

If Yes, What:_____

PETITIONER B CURRENT PERSONAL INFORMATION:

Full Name_____

All previous names you have ever used_____

_____

Present Street Address_____

City_____ County_____ State_____ Zip_____

ADDRESS FOR MAIL IF DIFFERENT THAN HOME ADDRESS_____

_____

Home Phone_____ Business Phone_____

Email_____ Cell Phone_____

Social Security Number_____

Length of Residence in Minnesota_____

Birthplace_____ Birthdate_____ Age_____

Religion_____ Race_____

Highest Level of Education_____ Year Completed_____

Present Health_____

Physician or Clinic_____

Are you presently in the military service?_____

PETITIONER B EMPLOYMENT INFORMATION (provide a current paycheck stub):

Employer_____

Address_____

Occupation_____

Length of Time with this Employer_____

How often are you regularly paid:
Weekly_____ Every two weeks_____ Twice per month_____ Monthly_____

ATTACH A CURRENT PAYCHECK STUB

Do you receive, or expect to receive, any of the following as income:

Public Assistance	☐ Yes ☐ No
Social Security Benefits for Yourself	☐ Yes ☐ No
Social Security Benefits for Child(ren)	☐ Yes ☐ No
Unemployment Compensation	☐ Yes ☐ No
Worker's Compensation	☐ Yes ☐ No
Rental Income	☐ Yes ☐ No
Other Income	☐ Yes ☐ No

If Yes, What:_____

BIOLOGICAL MOTHER PERSONAL INFORMATION:

Full Name_____

All previous names he/she has ever used_____

Present Street Address_____

City_____ County_____ State_____ Zip_____

Home Phone_____ Business Phone_____

Social Security Number_____

Length of Residence in Minnesota_____

Birthplace_____ Birthdate_____ Age_____

Religion_____ Race_____

Highest Level of Education_____ Year Completed_____

Present Health_____

Physician or Clinic_____

Is he/she presently in the military service?_____

ADDRESS FOR MAIL IF DIFFERENT THAN HOME ADDRESS_____

_____

BIOLOGICAL MOTHER EMPLOYMENT INFORMATION:

Employer_____

Address_____

Occupation_____

Length of Time with this Employer_____

Does he/she receive, or expect to receive, any of the following as income:

Public Assistance	☐ Yes	☐ No
Social Security Benefits for Himself/Herself	☐ Yes	☐ No
Social Security Benefits for Child(ren)	☐ Yes	☐ No
Unemployment Compensation	☐ Yes	☐ No
Worker's Compensation	☐ Yes	☐ No
Rental Income	☐ Yes	☐ No
Other Income	☐ Yes	☐ No

If Yes, What:_____

BIOLOGICAL FATHER PERSONAL INFORMATION:

Full Name_____

All previous names he/she has ever used_____

Present Street Address_____

City_____ County_____ State_____ Zip_____

Home Phone_____ Business Phone_____

Social Security Number_____

Length of Residence in Minnesota_____

Birthplace_____ Birthdate_____ Age_____

Religion_____ Race_____

Highest Level of Education_____ Year Completed_____

Present Health_____

Physician or Clinic_____

Is he/she presently in the military service?_____

ADDRESS FOR MAIL IF DIFFERENT THAN HOME ADDRESS_____

_____

BIOLOGICAL FATHER EMPLOYMENT INFORMATION:

Employer_____

Address_____

Occupation_____

Length of Time with this Employer_____

Does he/she receive, or expect to receive, any of the following as income:

Public Assistance	☐ Yes	☐ No
Social Security Benefits for Himself/Herself	☐ Yes	☐ No
Social Security Benefits for Child(ren)	☐ Yes	☐ No
Unemployment Compensation	☐ Yes	☐ No
Worker's Compensation	☐ Yes	☐ No
Rental Income	☐ Yes	☐ No
Other Income	☐ Yes	☐ No

If Yes, What:_____

Does he/she receive, or expect to receive, any of the following as income:

Public Assistance	☐ Yes	☐ No
Social Security Benefits for Himself/Herself	☐ Yes	☐ No
Social Security Benefits for Child(ren)	☐ Yes	☐ No
Unemployment Compensation	☐ Yes	☐ No
Worker's Compensation	☐ Yes	☐ No
Rental Income	☐ Yes	☐ No
Other Income	☐ Yes	☐ No

If Yes, What:_____

CHILDREN:

Children:

Full Name	Age	Birthdate	Social Security #

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do the children now live with Client? _____

Was a Delegation of Parental Authority (DOPA) ever signed? _____

IF SO, ATTACH A COPY.

Who are listed on the children's birth certificates?_____

What is the current visitation schedule, if any?

_____

_____

_____

To your knowledge, is there any protective or no contact order in place?_____

Has there ever been a custody order issued for the child(ren) listed above?(if so, attach a copy)_____

If you are asking for custody of a child that is not yours (i.e. third party custody), outline why you should be granted custody or parenting time and include any reasons why the parent(s) should lose custody of the child(ren):

_____

_____

_____

_____

_____

HEALTH INSURANCE FOR THE CHILD(REN):

	Name of Carrier	Coverage provided for: [Check all that apply] Policy Holder	Dependents
1.	Medical_____	_____	_____
2.	Dental_____	_____	_____
3.	Optical_____	_____	_____
4.	Other_____	_____	_____

Who carries this insurance?: _____

What is the MONTHLY cost for only the CHILD(REN)? _____

PROVIDE DOCUMENTATION SHOWING THE COST OF INSURANCE (I.E. COST OF FAMILY COVERAGE AND COST OF SINGLE COVERAGE)

DAYCARE:

If you incur daycare expenses, what is the weekly amount? _____

Is this amount pre-tax through employment (flex plan, etc.)? _____

PROVIDE DOCUMENTATION SHOWING THE COST OF DAYCARE.