Adoption For My Child

Providing adoption profiles on demand for available situations throughout the US

www.adoptionformychild.com team@adoptionformychild.com (801) 559-7444

"Aubrianna"

www.adoptionformychild.com/available-situations/Aubrianna/

****NOTE: This situation includes an advertising fee****

Date Posted:
06/04/2020

Application Deadline:
Ongoing

Open To:
All States **EXCEPT** New York

Mother's Location:
Florida

Due Date:
September 9, 2020

Level of Openness:
Open

Child's Ethnicity:
African-American

Child's Gender:
Unknown Gender

Requested Family Criteria:
All Family Types

Drug Exposure:
None Reported

Adoption Cost & Fee Breakdown

Cost - More Details

Outlined below are the estimated fees for this adoption. Please keep in mind fees are estimated, an expectant moms' needs can change during her pregnancy and unexpected changes can arise.

Advertising Fee	$15,800 ($9,000 refundable)
Coordinator Fee	$3,800
Estimated Living Expenses	$10,000
Agency/Legal	$7,500
Estimated Total	$36,100

TOTAL ESTIMATED COST OF THE ADOPTION: $36,100.00
(Basic Members - Please at $3,000 to total cost above for AFMC Networking Fee)

REFUNDED IF ADOPTION FAILS: see details below

DUE UPFRONT IF/WHEN YOU ARE CHOSEN
- AFMC Networking Fee (Basic Members Only): $3,000**
- AFMC Profile Submission Fee (Basic Members Only): $25

***Funds are due within 48 hours of being selected by the expectant mother.** Under NO circumstances should you submit your profile or request to be considered **UNLESS** you have the ability to immediate access to the liquid funding necessary to pay the upfront fees listed above. Please be realistic in regards to your ability to pay the total estimated cost of the adoption by the time the expectant mother delivers her child. If you do not have the total amount required for this adoption available, AFMC recommends that you get PRE-APPROVED for an adoption loan BEFORE you submit for this or any other situation that exceeds your current budget to make sure the adoption will not fall through due to an inability to pay.

HOW TO BE CONSIDERED BY THE EXPECTANT MOTHER

REQUIRED

- A completed **US Domestic Private** home study

- A PDF profile no more than 12 pages (including cover page) about your family with no contact information listed inside.***
***(IMPORTANT:** a link to an online profile WILL NOT be accepted)*

- **An active membership** with AFMC
(membership options start at $0 per month)

- Complete AFMC's "New Member Questionnaire"
(provided after you register for a membership)

- Read and sign AFMC's Service Agreement
(provided after "New Member Questionnaire" is completed)

OPTIONAL

- Letter to Expectant Mother
(providing one is highly encouraged, but not required

- Family Interview Video
Contact AFMC for more details

NOTE: All documents must be formally approved by AFMC before you can request to have your profile sent to the expectant mother.)

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Apply for this Situation

https://www.adoptionformychild.com/available-situations/Aubrianna/#request/

Contact Us

Email: team@adoptionformychild.com
Amy Senior Cell: (801) 559 - 7444 (call or text)

MEDICAL HISTORY

Medical Conditions

First Name
Aubrianna

1. Respiratory (Self)	Yes	No
Allergies	◉	○
Asthma	○	◉
Bronchitis	○	◉
Emphysema	○	◉
Tuberculosis	○	◉
Cystic Fibrosis	○	◉

(Family)	Yes	No
Allergies	○	◉
Asthma	○	◉
Bronchitis	○	◉
Emphysema	○	◉
Tuberculosis	○	◉
Cystic Fibrosis	○	◉

Comments (indicate family member etc)

2. Gastrointestinal (self)	Yes	No
Ulcers	○	◉
Inflammatory Bowel	○	◉
Cleft Lip or Palate	○	◉
Other	○	◉

(Family)	Yes	No
Ulcers	○	◉
Inflammatory Bowel	○	◉
Cleft Lip or Palate	○	◉
Other	○	◉

Comments (indicate family member etc)

3. Cardiovascular (self)	Yes	No
High Blood Pressure	○	◉
Heart Attack	○	◉
Stroke	○	◉
Congestive Heart Failure	○	◉
Atherosclerosis	○	◉
Heart Rhythm Abnormality	○	◉
Congenital Heart Defect	○	◉

(Family)	Yes	No
High Blood Pressure	○	◉
Heart Attack	○	◉
Stroke	○	◉
Congestive Heart Failure	○	◉
Atherosclerosis	○	◉
Heart Rhythm Abnormality	○	◉
Congenital Heart Defect	○	◉

Comments (indicate family member etc)

4. Immune/Hematological Condition (self)	Yes	No
Mononucleosis	○	◉
Hemophilia	○	◉
Leukemia	○	◉
Lymphomas	○	◉
Hodgkin's Disease	○	◉
Lupus	○	◉

(Family)	Yes	No
Mononucleosis	○	◉
Hemophilia	○	◉
Leukemia	○	◉
Lymphomas	○	◉
Hodgkin's Disease	○	◉
Lupus	○	◉

Comments (indicate family member etc)

5. Renal Condition (self)	Yes	No
Kidney Failure / Dialysis / Transplant	○	◉

(Family)	Yes	No
Kidney Failure / Dialysis / Transplant	○	◉

Comments (indicate family member etc)

	Yes	No
Other Kidney	○	◉

	Yes	No
Other Kidney	○	◉

6. Liver Disease (self)

	Yes	No
Hepatitis (specify)	○	◉
Cirrhosis	○	○
Other Liver Disease	○	◉

(Family)

	Yes	No
Hepatitis (specify)	○	◉
Cirrhosis	○	◉
Other Liver Disease	○	◉

Comments (indicate family member etc)

7. Central Nervous System Condition (self)

	Yes	No
Epilepsy	○	◉
Cirrhosis Hydrocephalus	○	◉
Multiple Sclerosis	○	◉
Huntington's Chorea	○	◉
Seizures / Convulsions	○	◉

(Family)

	Yes	No
Epilepsy	○	◉
Cirrhosis Hydrocephalus	○	◉
Multiple Sclerosis	○	◉
Huntington's Chorea	○	◉
Seizures / Convulsions	○	◉

Comments (indicate family member etc)

8. Endocrine (self)

	Yes	No
Diabetes (Adult or Juvenile)	○	◉
Thyroid (Hyper/Hypo)	○	◉
Adrenal	○	◉

(Family)

	Yes	No
Diabetes (Adult or Juvenile)	○	◉
Thyroid (Hyper/Hypo)	○	◉
Adrenal	○	◉

Comments (indicate family member etc)

9. Muscular/Skeletal (self)

	Yes	No
Club Foot	○	◉
Scoliosis	○	◉
Arthritis (Osteo or Rheumatoid)	○	◉
Lupus	○	◉

(Family)

	Yes	No
Club Foot	○	◉
Scoliosis	○	◉
Arthritis (Osteo or Rheumatoid)	○	◉
Lupus	○	◉

Comments (indicate family member etc)

10. Neuromuscular (self)

	Yes	No
Cerebral Palsy	○	◉
Muscular Dystrophy	○	◉
Spina Bifida	○	◉

(Family)

	Yes	No
Cerebral Palsy	○	◉
Muscular Dystrophy	○	◉
Spina Bifida	○	◉

Comments (indicate family member etc)

11. Visual/Auditory (self)

	Yes	No
Blindness	○	◉
Glaucoma	○	◉
Cataracts	○	◉
Deafness or Other Hearing Problems	○	◉

(Family)

	Yes	No
Blindness	○	◉
Glaucoma	○	◉
Cataracts	○	◉
Deafness or Other Hearing Problems	○	◉

Comments (indicate family member etc)

12. Mental and Behavioral Disorders (self)

(Family)

Comments (indicate family member etc)

	Yes	No
Diagnosed Schizophrenia	○	◉
Diagnosed Bi-Polar	○	◉
Other Mental Illness (Describe)	○	◉

	Yes	No
Diagnosed Schizophrenia	○	◉
Diagnosed Bi-Polar	○	◉
Other Mental Illness (Describe)	○	◉

13. Lymphatic Disorders (self)

	Yes	No
Cancer	○	◉
Tumors	○	◉
Cystic Fibrosis	○	◉
Hodgkins Disease	○	◉

(Family)

	Yes	No
Cancer	○	◉
Tumors	○	◉
Cystic Fibrosis	○	◉
Hodgkins Disease	○	◉

Comments (indicate family member etc)

14. Drugs Taken During This Pregnancy

	Yes	No
a. Prescription Drugs	○	◉

Details

	Yes	No
a. Non-Prescription Drugs (include asprin, nosedrops, etc)	○	◉

Details

c. Alcohol and other substances

	Yes	No
1. Alcohol (wine, beer, etc)	○	◉

Details

	Yes	No
2. Amphetamines (uppers)	○	◉

Details

	Yes	No
3. Barbiturates (downers)	○	◉

Details

	Yes	No
4. Tobacco	○	◉

Details

	Yes	No
5. Cocaine	○	◉

Details

	Yes	No
6. Crack	○	◉

Details

	Yes	No
7. Heroin	○	◉

Details

	Yes	No
8. LSD	○	◉

Details

	Yes	No
9. PCP	○	◉

Details

	Yes	No
10. Marijuana	○	◉

Details

	Yes	No
11. Other (specify)	○	◉

Details

Other: