



Adoption For My Child

Providing adoption profiles on demand for available situations throughout the US

www.adoptionformychild.com

team@adoptionformychild.com

[\(801\) 559-7444](tel:(801)559-7444)

"Samantha"

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

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

Date Posted:
05/24/2020

Application Deadline:
Ongoing

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

Mother's Location:
Florida

Due Date:
October 22, 2020

Level of Openness:
Open Updates

Child's Ethnicity:
Biracial, African-American,
Hispanic/Latino

Child's Gender:
Boy

Requested Family Criteria:
All Family Types

Drug Exposure:
None Reported

Additional Information:

Samenta is a very sweet 19 year old. She first contacted me in Feb, she was crying because her mother was going to force her to abort. Since then she has moved in with her 26 year old sister who is supportive of the adoption. I have also talked with the father who is very supportive of the adoption. This is a baby boy $\frac{3}{4}$ AA and $\frac{1}{4}$ Hispanic.

First Name: Samenta

State: Florida

What is Your Due Date?: 2020-10-22

Proof of Pregnancy? yes

Sex of Baby: male

Have you received prenatal care during this pregnancy? yes

How is the health of the baby? The baby is very healthy!

Any problems with pregnancy? No

Expectant Mother Age: 19

Birth Date: 2000-10-04

Ethnic Background: Black

Do you have any Native American Blood? no

If so, are you registered with a tribe? no

Have you ever placed a child for adoption? no

Who helped you with the adoption? Please list any agency, attorney or facilitator

Describe Your General Health: I'm healthy. I just have serve allergic reaction

Eye Color: Dark brown

Hair Color: Black

Height: 5'2

Weight: 190

Do you smoke? no

What is the last grade you completed? 12

Have you ever been diagnosed with Hepatitis C? no

Have you ever been diagnosed with HIV? no

Are you currently employed? no

Do you currently have medical coverage? yes

Are you open to meeting the family who adopts your baby? yes

Would you like pictures or updates after the baby is born? yes

Would you like visits after the baby is born? yes

Does your family know you are pregnant? yes

Does your family know about the adoption? no

Does your family agree? Yes, No

Does anyone in your family oppose adoption? no

Do You Have Other Children? no

Expectant Father First Name: Elmer

Date of Birth: 1995-12-04

Does he know about the adoption? yes

Does he support the adoption? yes

Are you legally married to the expectant father? no

Are you legally married to someone other than the expectant father? no

What is your current relationship with the birth father: Just friends

Father's Ethnic Background: Black, Hispanic

If so, is he registered with a tribe? no

Eye Color: Dark brown

Hair Color: Black

What is the last grade he completed? 12

Does anyone in his family oppose the adoption? No

Describe fathers general health: He is perfectly healthy

Has the expectant father ever been diagnosed with mental illness: No

Why are you considering adoption? To give our child a stable , loving home.

Since we are not ready for one the best thing to do is to give him to a loving , caring home

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.

Adverting Agency \$15,800 (9,000 refundable)

Adoption coodinator \$3,800

Estimated Living Expenses \$6,000

Agency/Legal \$7,000

Estimated Total \$32,600

TOTAL ESTIMATED COST OF THE ADOPTION: \$32,600.00

(Basic Members - Please at \$3,000 to total cost above for AFMC Networking Fee)

REFUNDED IF ADOPTION FAILS:

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.)

Apply for this Situation

<https://www.adoptionformychild.com/available-situations/Samantha/#request/>

Contact Us

Email: team@adoptionformychild.com
Amy Senior Cell: [\(801\) 559 - 7444](tel:8015597444) (call or text)

MEDICAL HISTORY

Medical Conditions

First Name

Samenta

1. Respiratory (Self)

	Yes	No
Allergies	<input checked="" type="radio"/>	<input type="radio"/>
Asthma	<input checked="" type="radio"/>	<input type="radio"/>
Bronchitis	<input type="radio"/>	<input checked="" type="radio"/>
Emphysema	<input type="radio"/>	<input checked="" type="radio"/>
Tuberculosis	<input type="radio"/>	<input checked="" type="radio"/>
Cystic Fibrosis	<input type="radio"/>	<input checked="" type="radio"/>

(Family)

	Yes	No
Allergies	<input type="radio"/>	<input checked="" type="radio"/>
Asthma	<input type="radio"/>	<input checked="" type="radio"/>
Bronchitis	<input type="radio"/>	<input checked="" type="radio"/>
Emphysema	<input type="radio"/>	<input checked="" type="radio"/>
Tuberculosis	<input type="radio"/>	<input checked="" type="radio"/>
Cystic Fibrosis	<input type="radio"/>	<input checked="" type="radio"/>

Comments (indicate family member etc)

2. Gastrointestinal (self)

	Yes	No
Ulcers	<input type="radio"/>	<input checked="" type="radio"/>
Inflammatory Bowel	<input type="radio"/>	<input checked="" type="radio"/>
Cleft Lip or Palate	<input type="radio"/>	<input checked="" type="radio"/>
Other	<input type="radio"/>	<input checked="" type="radio"/>

(Family)

	Yes	No
Ulcers	<input type="radio"/>	<input checked="" type="radio"/>
Inflammatory Bowel	<input type="radio"/>	<input checked="" type="radio"/>
Cleft Lip or Palate	<input type="radio"/>	<input checked="" type="radio"/>
Other	<input type="radio"/>	<input checked="" type="radio"/>

Comments (indicate family member etc)

3. Cardiovascular (self)

	Yes	No
High Blood Pressure	<input type="radio"/>	<input checked="" type="radio"/>
Heart Attack	<input type="radio"/>	<input checked="" type="radio"/>
Stroke	<input type="radio"/>	<input checked="" type="radio"/>
Congestive Heart Failure	<input type="radio"/>	<input checked="" type="radio"/>
Atherosclerosis	<input type="radio"/>	<input checked="" type="radio"/>
Heart Rhythm Abnormality	<input type="radio"/>	<input checked="" type="radio"/>
Congenital Heart Defect	<input type="radio"/>	<input checked="" type="radio"/>

(Family)

	Yes	No
High Blood Pressure	<input type="radio"/>	<input checked="" type="radio"/>
Heart Attack	<input type="radio"/>	<input checked="" type="radio"/>
Stroke	<input type="radio"/>	<input checked="" type="radio"/>
Congestive Heart Failure	<input type="radio"/>	<input checked="" type="radio"/>
Atherosclerosis	<input type="radio"/>	<input checked="" type="radio"/>
Heart Rhythm Abnormality	<input type="radio"/>	<input checked="" type="radio"/>
Congenital Heart Defect	<input type="radio"/>	<input checked="" type="radio"/>

Comments (indicate family member etc)

4. Immune/Hematological Condition (self)

	Yes	No
Mononucleosis	<input type="radio"/>	<input checked="" type="radio"/>
Hemophilia	<input type="radio"/>	<input checked="" type="radio"/>
Leukemia	<input type="radio"/>	<input checked="" type="radio"/>
Lymphomas	<input type="radio"/>	<input checked="" type="radio"/>
Hodgkin's Disease	<input type="radio"/>	<input checked="" type="radio"/>
Lupus	<input type="radio"/>	<input checked="" type="radio"/>

(Family)

	Yes	No
Mononucleosis	<input type="radio"/>	<input checked="" type="radio"/>
Hemophilia	<input type="radio"/>	<input checked="" type="radio"/>
Leukemia	<input type="radio"/>	<input checked="" type="radio"/>
Lymphomas	<input type="radio"/>	<input checked="" type="radio"/>
Hodgkin's Disease	<input type="radio"/>	<input checked="" type="radio"/>
Lupus	<input type="radio"/>	<input checked="" type="radio"/>

Comments (indicate family member etc)

5. Renal Condition (self)

	Yes	No
Kidney Failure / Dialysis / Transplant	<input type="radio"/>	<input checked="" type="radio"/>

(Family)

	Yes	No
Kidney Failure / Dialysis / Transplant	<input type="radio"/>	<input checked="" type="radio"/>

Comments (indicate family member etc)

Other Kidney Yes No
☐ ☒

Other Kidney Yes No
☐ ☒

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)

My Mother has diabetes

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)

Grandpa has glaucoma

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 aspirin, nosedrops, etc) ☒ ☐

Details

Name	When	How Often	Amount
Tylenol , and Benadryl	When necessary	3 days	2 Tylenol and 2 Benadryl

c. Alcohol and other substances

Yes No
 1. Alcohol (wine, beer, etc) ☐ ☒

Details

Yes No
 2. Amphetamines (uppers) ☐ ☒

Details

3. Barbiturates
(downers)

Yes No

☐ ☒

Details

4. Tobacco

Yes

No

☐ ☒

Details

5. Cocaine

Yes

No

☐ ☒

Details

6. Crack

Yes

No

☐ ☒

Details

7. Heroin

Yes

No

☐ ☒

Details

8. LSD

Yes

No

☐ ☒

Details

9. PCP

Yes

No

☐ ☒

Details

	Yes	No
10. Marijuana	<input type="radio"/>	<input checked="" type="radio"/>

Details

	Yes	No
11. Other (specify)	<input type="radio"/>	<input checked="" type="radio"/>

Details

Other: