Adoption For My Child

Providing adoption profiles on demand for available situations throughout the US

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

"Stephanie"

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

Date Posted:
04/30/2020

Application Deadline:
Ongoing

Open To:
All States

Mother's Location:
Florida

Due Date:
September 24, 2020

Level of Openness:
Semi-Open Pictures

Child's Ethnicity:
Multiracial, African-American, Caucasian, Native American

Child's Gender:
Girl

Requested Family Criteria:
All Family Types

Not Registered

Drug Exposure:
None Reported

Additional Information:
Stephanie is a 33 year old Caucasian/African American woman who is 19 weeks pregnant with an estimated due date of 9/24/2020. Gender of baby is girl. Due date and gender were determined by a non-diagnostic ultrasound on April 28, 2020. Race of baby will be Caucasian/African American/Native American.
• Stephanie reports a history of anemia during pregnancy.
• Stephanie reports she is Hep C positive
• Stephanie reports she has been diagnosed with Bi-polar Disorder, ADD, and Depression in 2012 by a psychiatrist.
• Stephanie reports she is currently receiving Suboxone treatment daily. She she currently receives 16 mg daily. She reports no opiate use for a 3 years and has received treatment for opiate use for 3 years.
• Stephanie reports she has been prescribed Klonopin .5mg daily for anxiety, Lithium 450 mg twice daily for bi-polar management, Gabapentin 400 mg daily for mood stabilizing, Latuda 80 mg daily for Depression, Wellbutrin 300 mg daily for Depression by her psychiatrist but is awaiting her next visit to determine prescription management now that she is aware of pregnancy.
• Stephanie reports cigarette use daily. Less than 1 pack per day.
• Stephanie reports she miscarried at 12 weeks gestation in 2019 for inconclusive reasons.
Stephanie has not started prenatal care but has been medicaid approved and is seeking an OB care provider.
Stephanie reports the birth father is known. The agency has communicated with the birthfather, who states he is supportive of her adoption plan and intends to sign his consent documents in May.
Stephanie reports having other children who are not in her care.
Stephanie would like a semi-open adoption with pictures and updates until the child is 18 years old.

Adoption Cost & Fee Breakdown

Cost - More Details

PLEASE NOTE THIS IS JUST AN ESTIMATE.

The agency provides us with the estimated adoption fees.

Stephanie's living expense estimated budget is $13,500-15,500

Match fee $20,000

Placement Fee $15,000

(Fees do not include birthparent counseling or birth parent attorney fees)

TOTAL ESTIMATED COST OF THE ADOPTION: $50,000.00

(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.

****Upgrade your membership to Elite or Ultimate level before submitting your request to avoid paying this fee

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/Stephanie/#request/

Contact Us

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

Biological Mother's Social/Medical History

(please print and use black or blue ink)

Today's Date: April 22, 2020	Due Date:	or Weeks Along: 16 weeks

Name: First	Middle	Last	Maiden
Stephanie			

Current Address (No PO Boxes)

City	State	Zip	County

Can we leave identifying messages?	Email Address
Home Phone: _____ ☐ Yes ☐ No	
Cell Phone: _____ ☒ Yes ☐ No	Social Security Number
Work Phone: N/A ☐ Yes ☐ No	

Emergency Contact Person: list someone who is aware that you are considering adoption. We will only contact this person in a case of an emergency.

Name Mary Relationship to you Mother Phone

Date of Birth	Place of Birth (City, State, County)
86	FL

Driver's License or ID (State and Number) Expiration Date

Your Race: (check all that apply)

☐ Caucasian ☐ African-American ☐ Hispanic ☐ Native American ☐ Asian ☐ Other: _____

Nationality: (for example, French, German, Irish)

Marital Status: ☒ Never married ☐ Married ☐ Separated ☐ Divorced

If Married, name of husband: _____ Any previous marriages: _____

If divorced (Date, County & State Finalized):

U.S Citizen: ☒ Yes ☐ No If No, passport/visa #:

Height	Weight (Before pregnancy)	Eye Color	Blood Type
5'2	145-150	hazel	A+

Skin Color: ☐Fair ☒Olive ☒Tan ☐Dark ☐Other:	Hair Color: ☐Blonde ☒Brown ☐Red ☐Other: Hair Texture: ☐Straight ☒Naturally Curly ☐ Wavy ☐ Other:

Body Structure	Hand dominance: ☒Right ☐ Left

Please list any other medical issues that were not covered in the information above:

_____

_____

Please list any additional comments, concerns or questions you may have that we may be able to assist you with:

_____

_____

I represent that the information contained in the Biological Mother's Social and Medical History is true and accurate. I acknowledge that the adoptive family and other parties will rely on this information in making a determination to proceed with the anticipated adoption and the Court will rely on this information during the adoption related proceedings. I hereby waive any claim of privilege and agree that the information contained on this form and any information provided by myself, my counselors and my physicians may be given to the adoptive parents, their agency, their attorney, other attorneys, and other state officials, including law enforcement authorities, through all communication medium.

I further understand that any false statements may be viewed as perjury and in violation of penal laws of my state and may subject me to criminal and/or civil penalties under the law. I also understand that it is unlawful for a parent, with the intent to defraud, to accept benefits related to the same pregnancy from more than one adoption entity without disclosing that fact to each entity.

In my written and verbal communications in connection with my adoption plan, I have not provided any false or misleading information of any kind including information concerning myself, the biological father or the background or medical history of my family.

I hereby authorize the Adoption Entity to make inquiry about the truthfulness of the statements made in this document and the circumstances of this placement with other medical, legal and adoption professionals through all communication medium.

Under penalties of perjury, I declare that I have read the foregoing and the facts stated in this document are true.

_____ 4-22-2020

Signature Date

CONFIDENTIAL DRUG/ALCOHOL USAGE

Please be very specific as to any drugs or alcohol used during your pregnancy, including the number of times and the dates of usage. This information is very important for the prediction of your child's health. This information will be passed along to the adoptive family and to the child's pediatrician. Place an '**X**' in the applicable boxes and leave blank all other boxes.

DRUG & ALCOHOL USAGE	Used occasionally (1-5 times) during pregnancy	Used daily during pregnancy	Used weekly during pregnancy	Used monthly during pregnancy
Alcohol	☐	☐	☐	☐
Anti-Convulsants	☐	☐	☐	☐
Crack/ Cocaine	☐	☐	☐	☐
Cigarettes	☐	☒	☐	☐
Depressants	☐	☐	☐	☐
Diet Pills	☐	☐	☐	☐
Ecstasy	☐	☐	☐	☐
Heroin	☐	☐	☐	☐
Hydrocodone	☐	☐	☐	☐
LSD/Acid/Schrooms	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐
Methamphetamines	☐	☐	☐	☐
Methadone	☐	☐	☐	☐
Oxycodone	☐	☐	☐	☐
Roxycodone	☐	☐	☐	☐
Stimulants (Caffeine included)	☐	☐	☐	☐
Tranquilizers	☐	☐	☐	☐

Please be specific about any prescription drugs used or prescribed during your pregnancy:

Name: _____ Prescribed for: _____

Length used: _____

Subutex - but trying to slowly taper off the Subutex
Clonopin
Litium
gabapentin
Latuda
wellbutrin

MEDICAL CONDITION	YOU		RELATIVE			
Crohn's Disease	☐	☐	☐	☐		
Lyme Disease	☐	☐	☐	☐		
Hepatitis	☐	☐	☐	☐		
Thyroid Disease/Disorder	☐	☐	☐	☐		
Diabetes (specify type)	☐	☐	☒	☐		
OTHER ILLNESSES	YES	NO	YES	NO	Relationship to you- be specific	ADDITIONAL INFORMATION
Kidney Stones	☒	☐	☐	☐		
Endometriosis	☐	☐	☐	☐		
Gall Stones	☐	☐	☐	☐		
Lupus	☐	☐	☐	☐		
Kidney Disease	☐	☐	☐	☐		
Liver Disease	☐	☐	☐	☐		
GENERAL HEALTH ISSUES	YES	NO	YES	NO	Relationship to you- be specific	ADDITIONAL INFORMATION
Hypoglycemia	☐	☐	☐	☐		
High Cholesterol	☐	☐	☐	☐		
Obesity	☐	☐	☐	☐		
Malnutrition	☐	☐	☐	☐		
Infertility	☐	☐	☐	☐		
Multiple Births (twins, triplets, etc)	☐	☐	☐	☐		
Premature Babies	☒	☐	☐	☐		
SIDS	☐	☒	☐	☐		
GENERAL HEALTH ISSUES	YES	NO	YES	NO	Relationship to you- be specific	ADDITIONAL INFORMATION
Congestive Heart Failure	☐	☐	☐	☐		
Ulcers	☐	☐	☐	☐		
Colitis	☐	☐	☐	☐		
*Gall Bladder Problems	☐	☐	☐	☐		

MEDICAL CONDITION	YOU		RELATIVE			
Emphysema	☐	☐	☐	☐		
Cystic Fibrosis	☐	☐	☐	☐		
Allergies	☐	☐	☐	☐		
Food Allergies	☐	☐	☐	☐		
Drug Allergies	☐	☐	☐	☐		
Tuberculosis	☐	☐	☐	☐		
SEXUALLY TRANSMITTED DISEASES	YES	NO	YES	NO	Relationship to you- be specific	ADDITIONAL INFORMATION
Gonorrhea	☐	☐	☐	☐		
Chlamydia	☐	☐	☐	☐		
Syphilis	☐	☐	☐	☐		
HIV / AIDS	☐	☐	☐	☐		
Herpes	☐	☐	☐	☐		
Pelvic Inflammatory Disease	☐	☐	☐	☐		
SKELETAL ABNORMALITIES	YES	NO	YES	NO	Relationship to you- be specific	ADDITIONAL INFORMATION
Dwarfism	☐	☐	☐	☐		
Osteoporosis	☐	☐	☐	☐		
Paralysis	☐	☐	☐	☐		
SKIN CONDITIONS	YES	NO	YES	NO	Relationship to you- be specific	ADDITIONAL INFORMATION
Psoriasis	☐	☐	☐	☐		
Eczema	☐	☐	☒	☐		
VISUAL CONDITIONS	YES	NO	YES	NO	Relationship to you- be specific	ADDITIONAL INFORMATION
Blindness	☐	☐	☐	☐		
Glaucoma	☐	☐	☐	☐		
Near Sighted	☐	☐	☐	☐		
Far Sighted	☐	☐	☐	☐		
Color Blindness	☐	☐	☐	☐		
Crossed Eyes	☐	☐	☐	☐		
Lazy Eye	☐	☐	☐	☐		
Cataracts	☐	☐	☐	☐		
OTHER ILLNESSES	YES	NO	YES	NO	Relationship to you- be specific	ADDITIONAL INFORMATION
Epilepsy/Seizures	☐	☐	☐	☐		
Tourette's Syndrome	☐	☐	☐	☐		

MEDICAL CONDITION	YOU		RELATIVE			
Hearing Impaired	☐	☐	☐	☐		
Speech Impaired	☐	☐	☐	☐		
Learning Disorder	☐	☐	☐	☐		
Dyslexia	☐	☐	☐	☐		
Emotionally Disturbed	☐	☐	☐	☐		
MENTAL HEALTH	YES	NO	YES	NO	Relationship to you- be specific	ADDITIONAL INFORMATION
Depression	☒	☐	☐	☒		
Suicide (including attempts)	☒	☐	☐	☒		
Alzheimer's Disease	☐	☒	☐	☒		
Autism	☐	☒	☐	☒		
Bi-Polar Disorder	☒	☐	☐	☒		
Schizophrenia	☐	☒	☐	☒		
Anorexia/Bulimia	☐	☒	☐	☒		
ADHD or ADD	☒	☐	☒	☐		
Other (specify)	☐	☒	☐	☒		
MUSCULOSKELETAL CONDITIONS	YES	NO	YES	NO	Relationship to you- be specific	ADDITIONAL INFORMATION
Cerebral Palsy	☐	☐	☐	☐		
Clubfoot	☐	☐	☐	☐		
Scoliosis	☐	☐	☐	☐		
Slipped disk	☐	☐	☐	☐		
Pinched nerve	☐	☐	☐	☐		
NEUROMUSCULAR CONDITIONS	YES	NO	YES	NO	Relationship to you- be specific	ADDITIONAL INFORMATION
Lou Gehrig's Disease	☐	☐	☐	☐		
Huntington's Disease	☐	☐	☐	☐		
Multiple Sclerosis	☐	☐	☐	☐		
Neurofibromatosis	☐	☐	☐	☐		
Parkinson's Disease	☐	☐	☐	☐		
Tay-Sachs Disease	☐	☐	☐	☐		
Muscular Dystrophy	☐	☐	☐	☐		
RESPIRATORY CONDITIONS	YES	NO	YES	NO	Relationship to you- be specific	ADDITIONAL INFORMATION
Asthma	☐	☒	☒	☐		

MEDICAL CONDITION	YOU		RELATIVE			
Prostate	☐	☐	☐	☐		
Lung	☐	☐	☐	☐		
Melanoma	☐	☐	☐	☐		
CANCER	YES	NO	YES	NO	Relationship to you- be specific	ADDITIONAL INFORMATION
Stomach	☐	☐	☐	☐		
Liver	☐	☐	☐	☐		
Colon	☐	☐	☐	☐		
Malignant Tumors	☐	☐	☐	☐		
Benign Tumors	☐	☐	☐	☐		
CARDIAC CONDITIONS	YES	NO	YES	NO	Relationship to you- be specific	ADDITIONAL INFORMATION
High Blood Pressure	☐	☒	☒	☐		
Heart Disease before age 50 (Coronary)	☐	☐	☐	☐		
Hypertension	☐	☐	☐	☐		
Murmur	☐	☐	☐	☐		
Stroke	☐	☐	☒	☐		
Heart Attack	☐	☐	☐	☐		
CHROMOSOMAL ABNORMALITIES	YES	NO	YES	NO	Relationship to you- be specific	ADDITIONAL INFORMATION
Down's Syndrome	☐	☐	☐	☐		
Turner's Disease	☐	☐	☐	☐		
Other chromosomal abnormality	☐	☐	☐	☐		
DENTAL CONDITIONS	YES	NO	YES	NO	Relationship to you- be specific	ADDITIONAL INFORMATION
Periodontal disease	☐	☐	☐	☐		
Gingivitis	☐	☐	☐	☐		
Overbite	☐	☐	☐	☐		
Underbite	☐	☐	☐	☐		
Dentures	☒	☐	☒	☐		
Multiple cavities	☐	☒	☐	☒		
EDUCATIONAL HANDICAPS	YES	NO	YES	NO	Relationship to you- be specific	ADDITIONAL INFORMATION
Mental Retardation	☐	☒	☐	☒		
Attention Deficit Disorder	☒	☐	☒	☐		
Hyperactivity	☐	☐	☒	☐		

HEALTH HISTORY OF BIOLOGICAL MOTHER

Place indicate by checking the appropriate box if the listed medical condition exists in your medical history or if any relatives or other family member have/had any of the conditions below. For any condition checked YES, please provide specific information as to the cause, treatment and age onset. If one of your relative's deaths was the result of a particular medical condition, note it on the additional information section and include the age at which they died.

MEDICAL CONDITION **YOU** **RELATIVE**

ARTHRITIS	YES	NO	YES	NO	Relationship to you- be specific	ADDITIONAL INFORMATION
Rheumatoid	☐	☐	☐	☐		
Osteo	☐	☐	☐	☐		
Juvenile	☐	☐	☐	☐		
BIRTH HANDICAPS	**YES**	**NO**	**YES**	**NO**	**Relationship to you- be specific**	**ADDITIONAL INFORMATION**
Cleft Palate	☐	☐	☐	☐		
Harelip	☐	☐	☐	☐		
Congenital Heart Defect	☐	☐	☐	☐		
Fetal Alcohol Syndrome	☐	☐	☐	☐		
Fetal Drug Exposure	☐	☐	☐	☐		
Hydrocephalus (water on the brain)	☐	☐	☐	☐		
Spina Bifida	☐	☐	☐	☐		
Born with hip problems	☐	☐	☐	☐		
Other birth handicaps	☐	☐	☐	☐		
BLOOD PROBLEMS	**YES**	**NO**	**YES**	**NO**	**Relationship to you- be specific**	**ADDITIONAL INFORMATION**
Anemia	☒	☐	☐	☐		
Hemophilia	☐	☒	☐	☐		
Leukemia	☐	☒	☐	☐		
Sickle Cell Trait	☐	☒	☐	☐		
Sickle Cell Disease	☐	☒	☐	☐		
Hepatitis	☒	☐	☐	☐		
CANCER	**YES**	**NO**	**YES**	**NO**	**Relationship to you- be specific**	**ADDITIONAL INFORMATION**
Breast	☐	☐	☐	☐		
Cervical	☐	☐	☐	☐		
Uterine	☐	☐	☐	☐		
Ovarian	☐	☐	☐	☐		
Hodgkin's Disease	☐	☐	☐	☐		
Bone	☐	☐	☐	☐		

Biological Mother's Extended Family

(complete to the best of your knowledge)

	Your Mother	Your Father	Your Sister(s)	Your Brother(s)
Name	Mary	Stephen	Christina	Bradley Scott
Age or Year of Birth	1965	1960		
Race	white	Blk / white / Indian		
Education				
Hobbies/ Interest				
Occupation		unemployed / disabled		
Height				
Weight				
Hair Color	brown	Dark brown	brown	Scott - ~~hazel~~ green brown Bradley - light brown
Eye Color	Hazel	brown	brown	Scott - green/blue Bradley -
Complexion (skin tone)	Light	Dark	Dark	Scott - Dark Bradley - light

MARITAL INFORMATION

If you were married at any time during your pregnancy and your husband is NOT the biological father of this baby, the courts require him to terminate his parental rights to the child. Please provide your husband's full name, permanent address, phone number with area code, social security number and date of birth:

If you do not know his address, what is the County and State of your husband's last known residence?

Please provide a physical description of your husband:

Age	Race	Height	Weight	Eye Color	Skin Color	Hair Color	Hair texture	Build

Is your husband aware of your pregnancy☐ Yes ☐ No

If yes, is he aware of your adoption plan? ☐ Yes ☐ No

If applicable, will your husband consent to the adoption? ☐ Yes ☐ No

CONTACT WITH THE ADOPTIVE FAMILY

Do you want to select the adoptive family? ☒ Undecided ☒ Yes ☐ No

Do you want pictures/letters from the family after the adoption? ☐ Undecided ☒ Yes ☐ No
If yes, for how long? Not sure yet

Do you want to meet the adoptive family at the time of placement? ☒ Yes ☐ No

Do you authorize us to disclose your name, address and phone number to the adoptive parents?

Please initial: Yes X No____

Please include any additional information you would like the adoptive family and your child to know about you or characteristics or preferences you would like to see in an adoptive family.

Please describe your relationship with the biological father. If you are no longer together, please state when the relationship ended and why.

NO Longer together
relationship ended ~~[illegible]~~ February 2020

Please list the date of the last contact with the biological father.

Are you involved in any litigation with the biological father? ☐ Yes ☐ No
If yes, please list the type of action, where it was filed and names of lawyers involved:

Is there any litigation pending regarding this child (custody, paternity, etc.)? ☐ Yes ☐ No
If yes, please list the type of action, where it was filed and names of lawyers involved:

Has he ever filed a petition to be declared the father of the child in any Court of otherwise been identified to be the father of the child? ☐ Yes ☐ No
If yes, what Court and when?

Has the birth father lived with you before or during the pregnancy? ☐ Yes ☐ No
If yes, when?

Has he given or offered any support financially or emotionally during this pregnancy? (Explain in detail.)

Was he ever physically or emotionally abusive to you during the pregnancy? (Explain in detail.)

NO

Please give the name, address and telephone number of any other man with whom you were living with at the time when conception of the child may have occurred.

P/A

Is there any possibility that any other man may be the biological father of the child? Why or why not?

no he was the only person I was with

Please provide a detailed description of any man/men you believe could be the father of the child:

	Age	Race	Height	Weight	Eye Color	Skin Color	Hair Color	Hair texture	Build
BF #1									
BF #2									
BF #3									

BIRTH FATHER INFORMATION

Do you know the identity of the birth father? ☒ Yes ☐ No

If yes, please provide his full name: Joey

Birth Father's Race: (check all that apply) white italian Cherokee Indian

☐ Caucasian ☐ African-American ☐ Hispanic ☐ Native American ☐ Asian ☐ Other:_____

Please provide the following: Date of birth	Social security number	Driver's license or state id number & state of issuance
1973		

Do you know where the biological father is now? ☒ Yes ☐ No

If yes, please provide his address, current phone number, including cell phone numbers:

If not known, please provide:

last known address: _____

last known phone number: _____

last known place of employment (including address & phone number): _____

Names, addresses and phone numbers of relatives (including but not limited to parents, brothers, sisters, aunts, uncles, cousins, nieces, nephews, grandparents, great-grandparents, former or current in-laws, stepparents, or step children who might know the biological father's identity or whereabouts):

Is the biological father in any branch of the Armed Services of the United States? ☐ Yes ☒ No

If yes, please list what branch and his last known location:

Is he also the father of any of your other child(ren)? ☐ Yes ☒ No

Does he know about the pregnancy? ☒ Yes ☐ No

If yes, when did you tell him you were pregnant?

Does he know of your adoption plan? ☒ Yes ☐ No

Does he agree with your adoption plan? ☒ Yes ☐ No

Will he sign paper to place the child for adoption? ☒ Yes ☐ No

If no or unknown, please explain:

How and when did you meet the birth father?

In december 2019 met thru a friend

HISTORY OF OTHER CHILDREN

Do you have other children? ☒ Yes ☐ No Do they currently live with you? ☐ Yes ☒ No
If no, please explain:

Name	Date of birth	Gender M/F	Height	Weight	Hair color	Eye Color	Complexion	Length of Pregnancy
Tray	02	M			brown	green	Tan	☐ Full term ☐ Overdue ☒ Premature
Makayla	04	f			brown	hazel	Tan	☒ Full term ☐ Overdue ☐ Premature
Damian	05	M			brown	blue	Tan	☒ Full term ☐ Overdue ☐ Premature
Carter	10	M			brown		accused	☐ Full term ☐ Overdue ☒ Premature
Aaliyah	12	f			brown	hazel	Tan	☒ Full term ☐ Overdue ☐ Premature

EMPLOYMENT AND EDUCATION HISTORY

Current Job/Employment: Unemployed

Number of Years Attended:

Grade School____ High School Ged College Some Other____

Educational Achievements:

Educational Goals: RN, Finish CNA

Hobbies/Interests:

PRENATAL CARE AND HOSPITAL INFORMATION

Are you receiving prenatal care? ☐ Yes ☒ No If yes, what month during your pregnancy did you start receiving prenatal care?_____ Does your Doctor/Clinic know about your adoption plan? ☐ Yes ☐ No	What doctor/clinic do you go to? Name: Address: Phone number with area code:

Please list all medical providers who have provided medical treatment or care to you and the child (include name, address, phone number).

None so far just now due to get proof of pregnancy

At which hospital will you be delivering?

Name: not sure yet

Phone number with area code:

Address:

MEDICAID / INSURANCE INFORMATION

MEDICAID INFORMATION: Do you have state issued Medicaid? ☒ Yes ☐ No I believe I still have medicaid If yes, what is your Medicaid number: not sure but I have my proof of pregnancy Medicaid worker's name and number: now to so im gonna submit that also so What county/state is your Medicaid issued through? I have pregnancy medicaid If no, are you willing to apply? ☒ Yes ☐ No	INSURANCE INFORMATION: Do you have medical insurance coverage? ☐ Yes ☐ No If yes, Company name:_____ Address: Phone number: What percentage of your insurance will cover this pregnancy?

NATIVE AMERICAN-INDIAN TRIBAL MEMBERSHIP

It is important for us to know if you are a member of, or qualify to be a member of, any Native American Indian tribe, in compliance with federal law. **Please answer the following questions fully, completely, and to the best of your knowledge:**

Are you a member of any Native American tribe? ☐ Yes ☒ No

Do you qualify to be a member of any Native American tribe? ☐ Yes ☒ No

If yes, please indicate the tribe, location and your registration or identification number:

_____

Do you currently or have you ever lived on an American Indian reservation? ☐ Yes ☐ No

Are any of your relatives members of any Native American Indian tribes? ☐ Yes ☐ No

Do any of your relatives qualify to be members of any Native American tribes? ☐ Yes ☐ No

PREGNANCY INFORMATION

Due Date: ☐Twins ☐ Triplets	Baby's Gender: ☐Boy ☐Girl ☒Unknown	Baby's Race:

When and how did you find out you are pregnant?

about two months ago or so took home pregnancy test

What city and state did you get pregnant in?

FL

Does anyone in your family know about your pregnancy? ☒ Yes ☐ No
If yes, who:

Do they know about your adoption plan? ☐ Yes ☐ No Are they supportive? ☐ Yes ☐ No

Whom do you currently live with and are they supportive of your adoption plans?

friend and yes they are supportive

Describe your feelings and reasons why you are placing your child for adoption:

because I am not financially stable enough to take care of a child and I also have other children I currently do not have custody of so I think for the child's best interest

On a scale of 1 to 10 with 1 representing a mild interest/curiosity about the adoption option and 10 representing an absolute resolve to place your baby for adoption, where would you consider yourself at this time?

Have you ever worked with another adoption agency or lawyer? If so, please list the name of the person or entity you worked with and the dates you worked with them:

Have you taken any medication during this pregnancy? If yes, what medication and when.

yes - prescribed

Have you been involved in any accidents during this pregnancy? If yes, please describe in detail.

NO

Have you had any complications with this pregnancy? If yes, please explain.

NO

Have you had X-ray, EKG, or radiation exposure during this pregnancy? If yes, please explain.

NO

PREGNANCY HISTORY

Is this your first pregnancy? ☐ Yes ☒ No	If no, how many prior pregnancies? 6

Did you have any problems during your prior pregnancies or births? If yes, please describe in detail.

1st child born @ 28 weeks
5th child born @ 23 weeks and passed away