

HEARTFELT ADOPTIONS AND SURROGACY SERVICES
ADOPTIVE PARENT APPLICATION
(Please type or print clearly as we rely on this information for court documents.)

Date: _____

Parent 1: _____ Parent 2: _____

Address: _____
Street City County State Zip

Home Phone: _____

Please list your name how it appears on your passport/driver's license.

PARENT 1

Name: _____

Maiden Name: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Employer: _____

Address: _____

Position: _____

How Long: _____

Annual Income: _____

Resided in Florida _____ Years

Birth Date: _____ Age: _____

Place of Birth: _____

U.S. Citizen? Yes No

If No, Where: _____

Race: _____

Ancestry: _____

Hair: _____ Eyes: _____ Height: _____

Weight: _____ Complexion: _____

Hobbies/Interests: _____

Date and Place of Marriage: _____

Has either spouse/partner filed for

separation, divorce, or annulment during this marriage? Yes No

Religious Affiliation: _____

PARENT 2

Name: _____

Maiden Name: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Employer: _____

Address: _____

Position: _____

How Long: _____

Annual Income: _____

Resided in Florida _____ Years

Birth Date: _____ Age: _____

Place of Birth: _____

U.S. Citizen? Yes No

If No, Where: _____

Race: _____

Ancestry: _____

Hair: _____ Eyes: _____ Height: _____

Weight: _____ Complexion: _____

Hobbies/Interests: _____

If wife is employed, will she take a leave of absence? Yes No

If so, how long? _____

Who will care for child after placement?

Religious Affiliation: _____

EDUCATION

PARENT 1

Graduated from high school? Yes No
Graduated from college? Yes No
Degree: _____
Major: _____

PARENT 2

Graduated from high school? Yes No
Graduated from college? Yes No
Degree: _____
Major: _____

PRIOR MARRIAGES

PARENT 1

Name of spouse: _____
How terminated: _____
When/where terminated: _____
Number of children: _____
Where/with whom do they reside: _____

*List other marriages on separate sheet.
Attach copies of all divorce decrees.*

PARENT 2

Name of spouse: _____
How terminated: _____
When/where terminated: _____
Number of children: _____
Where/with whom do they reside: _____

*List other marriages on separate sheet.
Attach copies of all divorce decrees.*

CHILDREN OF THIS MARRIAGE

Name: _____ DOB: _____ Adopted: _____ Biological: _____
Name: _____ DOB: _____ Adopted: _____ Biological: _____
If adopted, when and where: _____
Private Adoption Agency _____ Attorney _____ State Agency _____

FINANCIAL SUMMARY

Savings	\$ _____	Renting (Monthly Rent)	\$ _____
Savings & Investments	\$ _____	You budget range for adoption:	\$ _____
Home Market Value (Equity)	\$ _____	How will you finance adoption?	_____
Monthly Payments	\$ _____		
Mortgage Balance	\$ _____		

CHILD DESIRED

Review each question carefully as the answers you provide determine which birth parents view your family profile. The more restrictive your answers are, the fewer opportunities birth parents have to view your profile, which correlates to a longer wait.

ETHNICITY OF CHILD

Caucasian _____
Hispanic _____
African American _____
Caucasian/Hispanic _____
African American/Caucasian _____
Other (Please specify) _____

AGE OF CHILD

Newborn to Six Months _____
Six Months to One Year _____
One Year to Three Years _____
Three Years to _____ Years _____
Siblings _____

Desired Gender: Male Female Either (*If you are gender specific, waiting time may double*)

DRUG & ALCHOL USE BY THE BIRTH MOTHER

Please mark an “X” on what you are willing to accept regarding the birth mothers drug and alcohol usage. If, for example, you do not check alcohol during pregnancy we will not send your information to a birth mother that indicated they had one drink of alcohol. Think very carefully for each response. It should be noted that all medical and health history questions are answered by the birth parents and verifying the validity of each response is sometimes difficult or impossible. It is highly recommended that adoptive families research the effects of substance usage through a qualified medical professional.

Substance	1-5 Times	Monthly	Weekly	Daily
Cigarettes				
Alcohol				
Marijuana				
Cocaine				
Methamphetamine				
Heroin				
Ecstasy				
Methadone				
Diet pills				
Tranquilizers				
Other (please specify)				

** Please specify if there are any other substances that you would consider disqualifying in nature.*

BIRTH PARENT MEDICAL & FAMILY HISTORY

Mark an “X” if you are willing to accept a child whose parents have a medical or family history of such disorders. “Immediate family” means the parents of the biological parents.

Disorders	Birth Parents	Immediate Family
HIV/Aids		
Cancer		
Diabetes		
Mental Condition		
Physical Condition		
Down’s Syndrome		
Depressed		
Bi Polar		
Schizophrenia		
Sickle Cell Anemia		
Leukemia		
Cerebral Palsy		
* Other (please specify)		

** Please specify if there are any other conditions that you would consider disqualifying in nature.*

CONTACT WITH BIRTH PARENTS

- Would you like to have contact with birth parent(s) before adoption? __ Yes __ No
- Would you like to have contact with birth parent(s) after adoption? __ Yes __ No
- Would you be willing to send the birth parent(s) updates (letters, pictures, etc.) after the adoption? __ Yes __ No
 If so up to what age? _____
- Would you like to receive phone calls from birth parent(s)? __ Yes __ No
- Would you like to contact the birth parent(s) directly? __ Yes __ No
- Would you like contact with birth parent(s) through the agency only? __ Yes __ No
- Would you like to meet birth parent(s) in person? __ Yes __ No
- Would you like to attend any doctor visits with birth mom? __ Yes __ No

ADOPTION

- Have you been turned down by an adoption agency? __ Yes __ No
 If yes, please provide name of agency, date and reason: _____
-
- Do you have a completed home study? (If yes, please attach.) __ Yes __ No
 If so, please list the cost of your home study as well as the cost of your post placements: _____
-
- Name, address and phone number of agency or person doing home study: _____
-
- Why are you seeking to adopt a child? _____
-
- Are you working with another child placing entity at this time? __ Yes __ No
 If yes, who? _____
-
- How were you referred to Heartfelt Adoptions and Surrogacy Services? _____

BACKGROUND INFORMATION

Please mark an "X" as appropriate in the table below. If you mark an "X" under "Yes" be sure to indicate if it is applicable to the husband or wife, and explain the basis and outcome of the situation.

Have you ever?	Yes	No	Husband/ Wife	Explanation
Filed Bankruptcy				
Been in a Mental Hospital				
Had Psychotherapy				
Been Arrested				
Received a Discharge from the Military				
Placed a Child for Adoption				
Been Denied Custody by a Court				
Been Past Due on Child Support				
Been Involved in an Abuse Investigation				

MEDICAL INSURANCE POLICY COVERAGE

Name of Medical Insurance Company: _____
At what time (birth, temporary custody, finalization) does your insurance cover medical expenses for your baby?

Group Number or Policy Number: _____
Your medical insurance information will need to be released to the hospital after the birth of the baby to cover any medical bills. Every hospital is covered under strict confidentiality provisions and policies to protect your anonymity.

ATTACHMENTS

I/We have attached photographs of family.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I/We have attached a copy of our marriage certificate.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I/We have attached a copy of any/all divorce decrees.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I/We have attached a copy of our home study.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I/We have attached a copy of our medical insurance card (front and back).	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I/We have attached our family profile.	<input type="checkbox"/> Yes	<input type="checkbox"/> No