



### MAIN OFFICE

adoption@afth.org  
WYNNWOOD, PA  
30-31 Hampstead Circle  
Wynnewood, PA 19096  
610.642.7200

### BRANCH OFFICES

ALLENTOWN, PA  
2212 Union Blvd  
Allentown, PA 18109  
610.432.2384

CENTRAL PA  
5630 Linglestown Road  
Unit # 3012  
Harrisburg, PA 17112  
717.399.7766  
717.232.1787

PITTSBURGH, PA  
PO BOX 1472  
New Castle, PA 16103  
724.853.6533

NEW JERSEY  
451 Woodland Avenue  
Cherry Hill, NJ 08002  
856.665.5655  
732.335.8883

DELAWARE  
18-A Trolley Square  
Wilmington, DE 19806  
302.658.8883

VIRGINIA  
1407 Stephanie Way, Suite H  
Chesapeake, VA 23320  
757.361.0008  
804.218.2569

CONNECTICUT  
1 Regency Drive # 108  
Bloomfield, CT 06002  
860.657.2626

NEW YORK  
87 Mineola Blvd.  
2nd Floor  
Mineola, NY 11501  
800.355.5500

Services are provided to clients  
without regard to race,  
color, religion, ancestry, sex,  
marital status, disability,  
sexual orientation, gender identity,  
gender expression, age or limited  
English proficiency.

## EXPECTING/BIOLOGICAL PARENT APPLICATION

Name (First/Middle/Last):			Pronouns:		
Social Security #	-	-	Date of Birth:	/	/
Age:			Place of Birth:		
Race: <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Black/African-American <input type="checkbox"/> Asian <input type="checkbox"/> East Indian <input type="checkbox"/> Native American					
<input type="checkbox"/> Other (not of Hispanic/Latino origin) or 2+ Races:					
Nationality: <input type="checkbox"/> Hispanic or Latino Are you a member of a Indigenous Tribe or Alaskan Village? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Hair:		Eyes:		Height:	
Religion:					
Due Date/DOB:		Gender of baby:		Race/National Origin of baby:	
Your Mother's Name			Your Father's Name		
Marital Status <input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Single (Divorced) <input type="checkbox"/> Single (Widowed) <input type="checkbox"/> Married <input type="checkbox"/> Married (Separated)					
Please list your maiden name: _____					
Do you have any children? If so, please list full names and birth dates: _____					

### CONTACT INFORMATION

Street Address			
City	State	Zip	County
Email Address			
Phone (home)		Cell phone/Other	
What is the best way to contact you? _____ Can we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you reside: <input type="checkbox"/> Alone <input type="checkbox"/> With Parents <input type="checkbox"/> Other: _____			

### EMERGENCY CONTACT

Name of someone to contact in case of emergency:	Relationship to you:
Phone:	Email:

### EMPLOYMENT & EDUCATION

Highest level of education completed: <input type="checkbox"/> High School <input type="checkbox"/> GED <input type="checkbox"/> Technical School <input type="checkbox"/> College <input type="checkbox"/> Graduate School	
<input type="checkbox"/> Other: _____ Name of School: _____	
Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Employer: _____	
Have you ever served in the US military? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what branch? _____	
Do you have health insurance to cover prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
Insurance Company: _____	
Policy Holder's Name	Policy Number
Have you placed a child for adoption before? <input type="checkbox"/> Yes <input type="checkbox"/> No Was it with Adoptions From The Heart? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____	
Does anyone in your family know about the pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you in a safe environment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the other parent of the child aware that you are considering adoption? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe their feelings about this situation: _____	
What type of adoption are you seeking? <input type="checkbox"/> Open Adoption <input type="checkbox"/> Semi-Open Adoption <input type="checkbox"/> Closed Adoption <input type="checkbox"/> Unsure	

I am requesting counseling on options for myself and my child.

I understand that I am under no obligation to place my child for adoption by signing this application.

**By signing below you are consenting to receive e-news emails from Adoptions From The Heart (www.afth.org).**

Check here ☐ to OPT OUT. You can unsubscribe anytime by clicking the Unsubscribe link at the bottom of any email.

Signature	Date
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### REFERRAL SOURCE - Please tell us how you heard about Adoptions From The Heart:

- |                                                |                                           |                                                                                                    |
|------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Google                | <input type="checkbox"/> Past AFTH Client | <input type="checkbox"/> Attorney                                                                  |
| <input type="checkbox"/> Facebook/IG/YouTube   | <input type="checkbox"/> Doctor or Clinic | <input type="checkbox"/> Radio <input type="checkbox"/> TV <input type="checkbox"/> Tearoff Poster |
| <input type="checkbox"/> AFTH Website          | <input type="checkbox"/> Friend           | <input type="checkbox"/> Not sure                                                                  |
| <input type="checkbox"/> Other Internet: _____ | <input type="checkbox"/> Family Member    | <input type="checkbox"/> Other: _____                                                              |

Please Continue Application on Reverse.

## EXPECTING PARENT(S) APPLICATION

### Second Biological Parent

This portion of the application pertains to information on the biological parent of child.  
If any information is unavailable, please complete as much of the information below as possible.

Name (First/Middle/Last):	Pronouns:	Gender:
Social Security # - -	Date of Birth: / /	Age:
Place of Birth:		
Race: <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Black/African-American <input type="checkbox"/> Asian <input type="checkbox"/> East Indian <input type="checkbox"/> Native American		
<input type="checkbox"/> Other (not of Hispanic/Latino origin) or 2+ Races:		
Nationality: <input type="checkbox"/> Hispanic or Latino Are you a member of a Indigenous Tribe or Alaskan Village? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Hair:	Eyes:	Height:
Your Mother's Name		Religion:
Your Father's Name		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Do you have any children? If so, please list full names and birth dates:		

### CONTACT INFORMATION

Street Address			
City	State	Zip	County
Email Address			
Phone (home)		Cell phone/Other	
What is the best way to contact you? _____ Can we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you reside: <input type="checkbox"/> Alone <input type="checkbox"/> With Parents <input type="checkbox"/> Other: _____			

### EMERGENCY CONTACT

Name of someone to contact in case of emergency:	Relationship to you:
Phone:	Email:

### EMPLOYMENT & EDUCATION

Highest level of education completed: <input type="checkbox"/> High School <input type="checkbox"/> GED <input type="checkbox"/> Technical School <input type="checkbox"/> College <input type="checkbox"/> Graduate School <input type="checkbox"/> Other: _____
Name of School
Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Employer _____
Have you ever served in the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what branch? _____ Dates served _____
Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____
Does anyone in your family know about the pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe your feelings about considering adoption: _____
What type of adoption are you seeking? <input type="checkbox"/> Open Adoption <input type="checkbox"/> Semi-Open Adoption <input type="checkbox"/> Closed Adoption <input type="checkbox"/> Unsure

I am requesting counseling on options for myself and my child.

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Check here ☐ to OPT OUT. You can unsubscribe anytime by clicking the Unsubscribe link at the bottom of any email.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(if available)

Services are provided without regard to race, ethnicity, religious preference, national origin, disability, age or sex. The information on this form is of a confidential nature and will not be divulged to anyone outside Adoptions From The Heart without your permission. Your relatives will NOT be contacted in regard to this matter.