

**Lifetime Adoption Center**  
17860 Cattle Drive, Rough & Ready, CA 95975  
P.O. Box 967, Penn Valley, CA 95946

24 Hour Answer Line: 1-800-923-6784  
Toll-Free Fax: 1-877-293-3882



### Confidentiality Statement

All information you share with us is *completely* confidential.  
We only use this information to assist you in learning more about adoption for your specific situation.

## The Steps to Adoption...

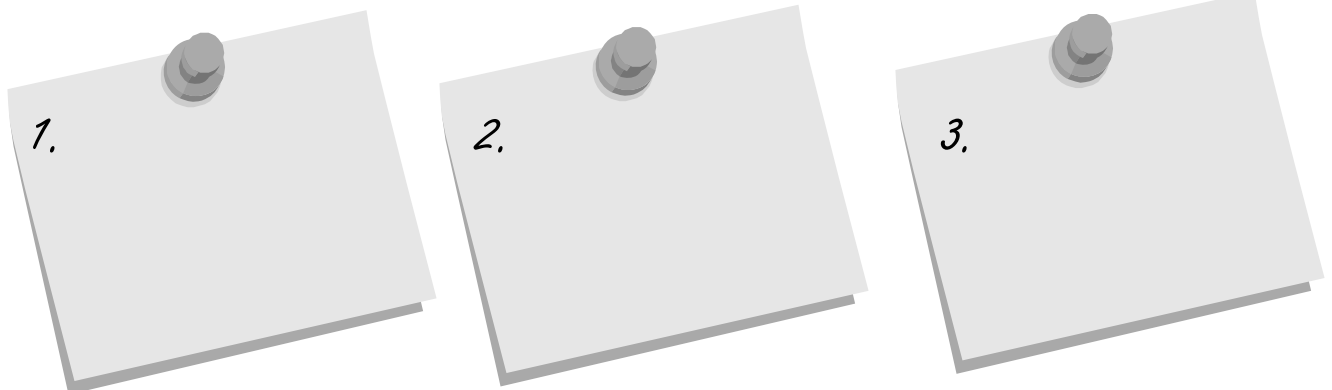
- **Please complete the attached forms and return to us.**
  - Obtain a “proof of pregnancy” if possible from your doctor or clinic.
  - Return both the paperwork and proof of pregnancy to us in the enclosed Federal Express envelope. You may call FedEx at 1-800-463-3339 to schedule a pick-up. They will come directly to you to pick up the envelope if you wish!
  - You may also fax the forms to our toll-free fax line at 1-877-293-3882.
  - If you wish, you may include a photo of yourself, the baby’s father or any children you may have.
- **Review the enclosed information about adoptive families.**
  - You may also visit our website ([www.LifetimeAdoption.com](http://www.LifetimeAdoption.com)) to see waiting families.
  - Decide on a first, second, or third choice.
  - You may call our office to learn more about the families and set up a phone call with them if you wish.
- **If you would like counseling at this time, please call your coordinator and let her know.**
  - We have phone counseling available.
  - We also have peer counseling available by women who have been where you are.
  - We can get you a support person to email with if you wish.

**We’re here to guide you through this process. We are only a phone call away, day or night.**

**1-800-923-6784**

**Or visit our website to chat live!**

## My Top 3 Adoptive Families Are...



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**Confidential Adoption Information Questionnaire**

Please complete as much of this form as you feel comfortable with. Sending in this paperwork does not require that you complete an adoption plan. It enables us to better help you in your unique situation.



*First, The Basics...*

Your Name

First

Middle

Last

Your Address

Street Address

Apartment #

City

State

Zip Code

Phone & E-mail

Home Phone

Cell Phone

E-mail Address

Confidential?

Yes

No

May we leave a message?

Yes

No

U.S. Citizen?

Yes

No

Your Date of Birth



*About Your Adoption Plan...*

What type of adoptive family are you looking for?

\_\_\_\_\_

What are your hopes & dreams for your child?

\_\_\_\_\_

Does your family know about your pregnancy?

\_\_\_\_\_

Will they support you in choosing an adoption plan?

\_\_\_\_\_

Will your friends support you in an adoption plan?

\_\_\_\_\_

What plans/goals do you have for the next 2 years?

\_\_\_\_\_

What would make you change your mind & decide to parent?

\_\_\_\_\_

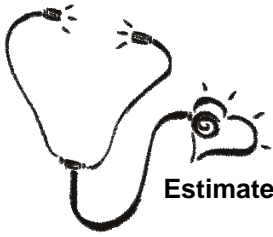
If you desire ongoing contact after the adoption with the adoptive family, please describe your wishes:

\_\_\_\_\_

Will you need financial assistance for your pregnancy-related expenses? If yes, please describe:

\_\_\_\_\_

\_\_\_\_\_



# About Your Health & Pregnancy...

Estimated due date? \_\_\_\_\_

Date of last period? \_\_\_\_\_

Have you seen a doctor?  Yes  No

Have you had an ultrasound?  Yes  No

Have you had complications?  Yes  No

Baby's gender, if known?  Boy  Girl

Your Doctor's Information: \_\_\_\_\_  
 Name City, State Phone

Hospital you plan to deliver at: \_\_\_\_\_  
 Name City, State Phone

Do you have insurance?  Yes  No Do you have Medicaid/MediCal?  Yes  No

Number of pregnancies you've had, including this one? \_\_\_\_\_ Any C-sections?  Yes  No

Number of: Miscarriages \_\_\_\_\_ Live Births \_\_\_\_\_ Abortions \_\_\_\_\_

## Health Background

Please check any of these conditions that you, your baby's father, or your families may have.

	You	Your Family	Baby's Father	His Family		You	Your Family	Baby's Father	His Family
HIV + or AIDS					Learning Disability				
Alcoholism					Mental Illness				
Allergies					Mental Retardation				
Arthritis					Migraines				
Asthma					Multiple Sclerosis				
Bipolar					Physical Disability				
Birth Defects					Psychiatric Treatment				
Blood Disorder					Respiratory Disorder				
Bowel Disease					Schizophrenia				
Cancer					Sickle Cell Anemia				
Depression					Sight Problems				
Epilepsy or Seizures					Suicide Attempts				
Gonorrhea					Syphilis				
Hearing Problems					Tay Sachs				
Heart Condition					Thyroid Condition				
Hepatitis: A, B, or C					Tuberculosis				
High Blood Pressure					Ulcers				
Herpes					Venereal Warts				
Kidney Disease									

Any other health conditions? \_\_\_\_\_

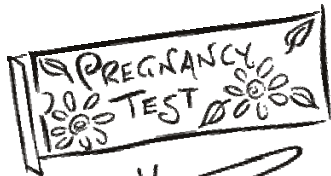
Medications you are taking? \_\_\_\_\_

During this pregnancy, have you: Smoked Cigarettes?  Yes  No How much? When? \_\_\_\_\_

Used Alcohol?  Yes  No How much? When? \_\_\_\_\_

Used Marijuana?  Yes  No How much? When? \_\_\_\_\_

Used Drugs?  Yes  No How much? When? \_\_\_\_\_





# A Little More About You...

Do you work? \_\_\_\_\_

If so, what do you do? \_\_\_\_\_

Last school attended? \_\_\_\_\_

Highest grade completed? \_\_\_\_\_

Natural Hair Color? \_\_\_\_\_

Eye Color? \_\_\_\_\_

Complexion? \_\_\_\_\_

Current Weight? \_\_\_\_\_

Height? \_\_\_\_\_

Pre-pregnancy Weight? \_\_\_\_\_

Your Race? \_\_\_\_\_

Any Native American Heritage? \_\_\_\_\_

Are you legally married?  Yes  No

Married to baby's father?  Yes  No

Have you been arrested?  Yes  No

If arrests, please explain? \_\_\_\_\_

Do you have any children?  Yes  No

If yes, do they live with you?  Yes  No

What are their ages? \_\_\_\_\_



# About the Father of Your Baby...

His Name

First

Middle

Last

His Address

Street Address

Apartment #

City

State

Zip Code

Phone & E-mail

Home Phone

Cell Phone

E-mail Address

U.S. Citizen?  Yes  No

His Age or Date of Birth \_\_\_\_\_

Does he work? \_\_\_\_\_

If so, what does he do? \_\_\_\_\_

Hair Color? \_\_\_\_\_

Eye Color? \_\_\_\_\_

Complexion? \_\_\_\_\_

Height? \_\_\_\_\_

His Race? \_\_\_\_\_

Any Native American Heritage? \_\_\_\_\_

Does he know you're pregnant?  Yes  No

Does he know you're considering adoption?  Yes  No

Has he helped you financially?  Yes  No

Does he wish to meet the adoptive parents?  Yes  No

Have you lived with him?  Yes  No

Has he acknowledged the child is his?  Yes  No

Does he have other children?  Yes  No

Does he have a history of drug use?  Yes  No

Has he been arrested?  Yes  No

Please explain: \_\_\_\_\_

Do you believe he is willing to agree to the adoption and sign the necessary legal papers?  Yes  No



# Other Things You May Wish to Share

Favorite Color? \_\_\_\_\_

Favorite Food? \_\_\_\_\_

Special Talents? \_\_\_\_\_

Favorite Hobby? \_\_\_\_\_

Music You Like? \_\_\_\_\_

Favorite Movie? \_\_\_\_\_

Favorite Pet? \_\_\_\_\_

I want to learn to... \_\_\_\_\_

One thing I'd like my child to know about me... \_\_\_\_\_

One thing I'd like adoptive family to know about me... \_\_\_\_\_

## Statement of Understanding

**DESCRIPTION:** Lifetime Adoption Center, LLC is solely engaged in the business of adoption facilitation, as defined by the State of California, Family Code: "Adoption facilitators may advertise for the purpose of soliciting parties to an adoption or locating children for an adoption, and may act as an intermediary between the parties to an adoption." Adoption facilitation is governed by the laws of California, but is not subject to licensing by the State of California.

**ACKNOWLEDGMENT:** I have been informed and fully understand that Lifetime Adoption Center, LLC has not presented itself as, and is not a private or public licensed adoption agency, a licensed psychotherapist or counselor, an attorney, a law firm, an Adoptive Service Provider (ASP), an investigator, an adoption advertising service nor a Licensed Clinical Social Worker (LCSW). I understand that Lifetime Adoption Center, LLC is not licensed to provide legal or therapeutic services and does not offer or provide services (in this office) in these or other capacities described in this paragraph. All of these services are referred out of this office.

I understand that a qualified adoption attorney and/or adoption agency will process a legal and ethical adoption for me, my child (children), and the family I select. I understand I have the right to select or reject any adoptive parents for any reason, and that Lifetime Adoption Facilitation Center, LLC does not make decisions concerning my selection of adoptive parents. I understand that I have the right to seek separate legal representation.

**REPRESENTATION:** I am not currently associated with any professional, formally or informally, who might assist me to locate a family to adopt my child (children). I am not currently communicating with any prospective adoptive parents concerning the adoption of my child (children).

**By signing this document, I agree that I will not seek services from anyone other than Lifetime Adoption Center, LLC to locate a family to adopt my child (children), unless I first advise Lifetime Adoption Center, LLC that I intend to use other services as well, or advise Lifetime Adoption Center, LLC in writing that I no longer require their services.**

**WAIVER OF CONFIDENTIALITY:** I hereby authorize Lifetime Adoption Center, LLC and any of its representees to share all information provided by me with any prospective adoptive parents who may be interested in adopting my child (children), or any representative acting on their behalf, or on my behalf, and with any professional otherwise connected with the adoption plan.

By signing this agreement, I also agree to provide true and accurate information to the best of my ability, under penalty of perjury.

**FINANCIAL ASSISTANCE:** I understand that I may or may not be permitted to receive financial assistance from adoptive parents, in accordance with the laws of my state and the state the adoptive parents reside in. I understand that it is illegal to obtain financial benefits from prospective parents for the payment of hospital or medical expenses, living expenses, or any other financial benefits, with the intent to receive the benefits and not complete this adoption or consent to the adoption. Such action is punishable to the full extent of the law. I have discussed this entire document with a representative of Lifetime Adoption Center, LLC.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Name \_\_\_\_\_

Driver's License #: \_\_\_\_\_

Social Security #: \_\_\_\_\_

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**Authorization for Physician/Clinic Release of Health Information**

**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

1. I hereby authorize Dr. \_\_\_\_\_  
*(Name of All Doctors involved with this pregnancy)*  
to disclose my health information related to my medical treatment.

2. Please release this information to Lifetime Adoption Center, its founder, Mardie Caldwell, COAP, or any of its employees or representatives located in Penn Valley or Rough & Ready, California.

3. The records and information to be released include any and all medical, health, or other information including birth records, birth certificates, or other documentation pertaining to me and my pregnancy.

4. My **initials** acknowledge I authorize release of the following information:

- \_\_\_\_\_ Psychiatric, behavioral health, or mental health records.
- \_\_\_\_\_ Drug and/or alcohol use/abuse records.
- \_\_\_\_\_ AIDS/HIV or other sexually transmitted disease records.

5. I understand that this information may be used in considering, planning for, or in connection with proceedings in preparation of an adoption plan for my child.

6. I understand that this authorization:

- Prohibits further use or disclosure of the information being released beyond the specific limits of this consent;
- Expires six months from the date of signature;
- I have the right to revoke this authorization by writing to the healthcare provider listed above;
- Is completed voluntarily;
- May be revoked at any time at my request; and
- Allows me the right to receive a copy of this authorization.

**7. Please send the information to Lifetime's secure fax at 1-877-293-3882 if possible.**

Thank you for your prompt attention to the release of this information.

\_\_\_\_\_  
Signature of Patient, Parent, or Guardian

\_\_\_\_\_  
Date

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**Authorization for Hospital Release of Health Information**

**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

1. I hereby authorize \_\_\_\_\_  
(Name of Hospital)

to disclose my health information related to my medical treatment.

2. Please release this information to Lifetime Adoption Center, its founder, Mardie Caldwell, COAP, or any of its employees or representatives located in Penn Valley or Rough & Ready, California.

3. The records and information to be released include any and all medical, health, or other information including birth records, birth certificates, or other documentation pertaining to me and my pregnancy.

4. My **initials** acknowledge I authorize release of the following information:

- \_\_\_\_\_ Psychiatric, behavioral health, or mental health records.
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**Attention Hospital Personnel**  
Please place this form in patient's chart and notify Labor & Delivery.

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_



## My Open Adoption Plan

Open adoption means that you have the opportunity to make choices that affect you. You may want to make these choices or you may prefer to leave them to others. This form will be made available to hospital staff and your chosen family so they are aware of your preferences.

**My Doctor:** \_\_\_\_\_  
Name Phone

**My Hospital:** \_\_\_\_\_  
Name Phone

**My Adoption Professional:** Lifetime Adoption Center 1-800-923-6784

*While I am in the hospital, I would like...*

To see the baby?  Yes  No To know the gender of the baby?  Yes  No

To hold the baby?  Yes  No To order my set of newborn photos?  Yes  No

A private room, if possible?  Yes  No A non-maternity floor, if possible?  Yes  No

The following people to be allowed in the delivery room with me:

\_\_\_\_\_

The following people to see and/or hold the baby?

\_\_\_\_\_

Any other special requests?

\_\_\_\_\_

If possible, for the umbilical cord to be cut by: \_\_\_\_\_

At discharge, I would prefer to leave  Before  After  At the same time the adoptive parents & baby leave.

Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_