

Step Parent Adoption Questionnaire

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Petitioner's Information:

Petitioner is the person adopting the child.

First Name:			
Middle Name:			
Last Name:			
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Registered Domestic Partnership		
	Date of marriage or registry:		
Date of Birth (mm/dd/yyyy):			
Race (Check all that apply):	Spanish/Hispanic/Latino?		
<input type="checkbox"/> White	<input type="checkbox"/> No, not Spanish/Hispanic/Latino		
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Yes, Cuban		
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes, Mexican/Mexican American/Chicano		
<input type="checkbox"/> Asian	<input type="checkbox"/> Yes, Puerto Rican		
<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Other Spanish/Hispanic/Latino		
Telephone Number:	()		
E-mail Address:			
Additional info add here:			

Petitioner's Address:

Address			County		
City		State		ZIP Code	
Which county will you be filing in:					

Petitioner's Spouse Information:

Spouse is the biological parent of the child being adopted by the petitioner.

First Name:	
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Middle Name:			
Last Name:			
Relation to child:	<input type="checkbox"/> Mother <input type="checkbox"/> Father		
Date of Birth (<i>mm/dd/yyyy</i>):			
Race (Check all that apply):	Spanish/Hispanic/Latino?		
<input type="checkbox"/> White	<input type="checkbox"/> No, not Spanish/Hispanic/Latino		
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Yes, Cuban		
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes, Mexican/Mexican American/Chicano		
<input type="checkbox"/> Asian	<input type="checkbox"/> Yes, Puerto Rican		
<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Other Spanish/Hispanic/Latino		
Date of Birth (<i>mm/dd/yyyy</i>):			
Telephone Number:	()		
E-mail Address:			
Additional info add here:			

Native American or Alaska native Ancestry

Does the spouse have any Native American or Alaska native Ancestry?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, include the name of any tribe(s) in spouse's ancestry and indicate whether or not spouse is a member:	
Is the parent a member of the military service on active duty?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Child's Information:

First Name:			
Middle Name:			
Last Name:			
Change Child's Name to:			
Additional info add here:			

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Native American or Alaska native Ancestry

Does the child have any Native American or Alaska native Ancestry?	(<input type="checkbox"/>) Yes (<input type="checkbox"/>) No
If yes, include the name of any tribe(s) in child's ancestry and indicate whether or not child is a member:	

Child's Birth and Race Information:

Gender:	(<input type="checkbox"/>) Male (<input type="checkbox"/>) Female		
Date of Birth (mm/dd/yyyy):			
Name Of Hospital:			
County:			
City:			
State:			
Race (Check all that apply):	Spanish/Hispanic/Latino?		
(<input type="checkbox"/>) White	(<input type="checkbox"/>) No, not Spanish/Hispanic/Latino		
(<input type="checkbox"/>) Black or African American	(<input type="checkbox"/>) Yes, Cuban		
(<input type="checkbox"/>) American Indian/Alaska Native	(<input type="checkbox"/>) Yes, Mexican/Mexican American/Chicano		
(<input type="checkbox"/>) Asian	(<input type="checkbox"/>) Yes, Puerto Rican		
(<input type="checkbox"/>) Native Hawaiian or Pacific Islander	(<input type="checkbox"/>) Other Spanish/Hispanic/Latino		

Child's Special Needs and/or Medical Conditions?

Does this child have special needs?	(<input type="checkbox"/>) Yes (<input type="checkbox"/>) No (<input type="checkbox"/>) Unable to determine		
Special needs basis (Check all that apply):	<input type="checkbox"/> Not Applicable <input type="checkbox"/> Medical conditions or mental, physical, or emotional disabilities. <input type="checkbox"/> Age <input type="checkbox"/> Racial/origin background <input type="checkbox"/> Part of a Sibling group <input type="checkbox"/> Other:		
Medical Conditions of Mental, Physical, or Emotional disabilities (Check all that apply):	<input type="checkbox"/> Not Applicable <input type="checkbox"/> Mental retardation <input type="checkbox"/> Visual/hearing impaired <input type="checkbox"/> Physical disability <input type="checkbox"/> Emotional disability <input type="checkbox"/> Other medical disability:		

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Child's Address for the past 5 years:

Complete information concerning any other places where the child lived in the ***past five years***, and the names and current address of the persons with whom the child has lived during that period is provided here:

1.) Child resides now with (person(s)):		
Child has resided here since:		
Address:		
2.) Child resided with (person(s)):		
From:		To:
Address:		
Person(s) now resides:		
3.) Child resided with (person(s)):		
From:		To:
Address:		
Person(s) now resides:		
4.) Child resided with (person(s)):		
From:		To:
Address:		
Person(s) now resides:		
Additional info add here:		

Other Biological Parent's Information

The biological parent whose parental rights are being terminated:		<input type="checkbox"/> Father <input type="checkbox"/> Mother	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this parent in agreement with terminating their rights? If not there may be additional costs for service fees and/or publication by newspaper depending on their whereabouts.		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the parent is deceased?	If yes, date:	
First Name:			
Middle Name:			
Last Name:			

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Race (Check all that apply):		Spanish/Hispanic/Latino?	
<input type="checkbox"/> White		<input type="checkbox"/> No, not Spanish/Hispanic/Latino	
<input type="checkbox"/> Black or African American		<input type="checkbox"/> Yes, Cuban	
<input type="checkbox"/> American Indian/Alaska Native		<input type="checkbox"/> Yes, Mexican/Mexican American/Chicano	
<input type="checkbox"/> Asian		<input type="checkbox"/> Yes, Puerto Rican	
<input type="checkbox"/> Native Hawaiian or Pacific Islander		<input type="checkbox"/> Other Spanish/Hispanic/Latino	
Date of Birth (mm/dd/yyyy):			
Telephone Number:		()	
E-mail Address:			
Marital Status at the time of birth:		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Unable to determine	
Additional info add here:			

Parent's Address:

Address:		County:	
City:	State:	Zip Code:	
Does the parent have any Native American or Alaska native Ancestry?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, include the name of any tribe(s) in the parent's ancestry and indicate whether or not parent is a member:			
Is the parent a member of the military service on active duty?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional info add here:			