



Baptist Children's Home & Family Services

APPLICATION FOR MATERNITY SERVICES

Date of Admission _____ Please type or print all answers

Name _____
Last First Middle

Address _____
Street, Number & Apartment #

Town County State Zip Code

Telephone Number _____ / _____ Birthdate _____ Race _____

Social Security Number _____

Birthplace _____
Town County State

Please bring certified copy of your birth Certificate.

Services Requested: Maternity Home _____ Counseling _____ Out-Patient Services _____
Adoptive Placement _____ Undecided _____
Other _____

Who will be responsible for maternity expenses? _____

Alleged Father: Name _____ Address _____

Birthdate _____ Race _____ Phone _____

Occupation _____

Does alleged father of your child know that you are pregnant? _____

Does alleged father of your child know you are planning to go to a maternity home? _____

Will alleged father of your child assist you financially? _____

Are you and the alleged father in agreement with future plans for your child? _____

List any hereditary diseases in alleged father's family _____

PERSONAL DATA

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Note: If divorced or widowed is checked, give date here _____

Please bring your marriage and/or divorce papers with you.

Religion: Baptist _____ Protestant _____ Catholic _____ Other _____ None _____

Education: Check highest level and circle highest grade completed:

1) Elementary School _____ 1 2 3 4 5 6 7 8

2) High School _____ 9 10 11 12

3) College _____ 1 2 3 4

Degree _____ in _____ Major

4) Other _____ 1 2 3 4

Type of Training _____

5) Graduate work _____ 1 2 3 4

Degree _____ in _____ Area

Name and address of last school attended: _____

Present Occupation: _____

Previous Occupation: _____

Hobbies, Special Interest: _____

How did you learn of this agency? Please supply name & address of referring person or agency.

Pastor _____

Physician _____

Attorney _____

Other _____

List any other agencies working with you:

Name	Address	Worker	Dates

FAMILY DATA

Parents

Marital Status: Married _____ Separated _____ Divorced _____ Other _____

If your parents are divorced or separated, and you are under age 18, who holds legal custody of you? _____

FATHER

MOTHER

Name _____

Name _____

Address _____
Street, Number or Apt #

Address _____
Street, Number or Apt #

Town _____ State _____ Zip Code _____

Town _____ State _____ Zip Code _____

Telephone _____
Area Code

Telephone _____
Area Code

Name & address of Step Parents: _____

Guardian: _____

Do your parents know that you are pregnant? Yes _____ No _____

Whom shall we notify in emergency? _____

Other family members:

Number of : Brothers _____ Sisters _____

How many live at home? _____

Other family members in your home? _____

When do you want to enter our program? _____

MEDICAL DATA

Have you been seen by a physician? _____ If yes, please give due date _____

Physician's Name: _____

Address: _____

Is this your first pregnancy? _____ If no, please explain _____

Do you have any physical handicap? _____ If so, please specify: _____

Are you taking any medication? _____ What is it? _____

Have you ever been under treatment for a nervous or mental disorder? _____ If so, please specify _____

Have you had or do you have any contagious disease? _____ If so, state nature of disease and what treatment you have had or are receiving. _____

Have you ever had any serious illness? _____ If so, please specify _____

Do you have any serious allergies? _____

Please tell how we can best help you in the next few months. _____

Signature of Applicant

If under 18 yrs of age, signature of parent or guardian is required.

Signature of Parent/Guardian

Please return this application to:

Angels' Cove
Ministry of Baptist Children's Home & Family Services
4243 Lincolnshire Drive
Mt. Vernon, IL 62864