

Step Parent Adoption Questionnaire

Petitioner's Information:

Petitioner is the person adopting the child.

First Name:			
Middle Name:			
Last Name:			
Is the Petitioner in the Military?	(<input type="checkbox"/>) Yes (<input type="checkbox"/>) No		
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:	County / State of marriage:	
Date of Birth (mm/dd/yyyy):			
SS#	Driver's license #		
(<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:			
Middle Name:			

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Last Name:			
Is the Petitioner's Spouse in the Military?	(<input type="checkbox"/>) Yes (<input type="checkbox"/>) No		
Gender:	(<input type="checkbox"/>) Male (<input type="checkbox"/>) Female		
Relation to child:	(<input type="checkbox"/>) Mother (<input type="checkbox"/>) Father		
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		
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:			
Telephone Number:	()		
E-mail Address:			
SS #:			
Driver's License #:			

Child's Information:

First Name:			
Middle Name:			
Last Name:			
Mother's Name at time of birth:			
Change Child's Name to:			
Additional info add here:			

Child's Birth and Race Information:

Gender:	(<input type="checkbox"/>) Male (<input type="checkbox"/>) Female		
Date of Birth (mm/dd/yyyy):			

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Time of Birth (09:30 a.m.)		
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	
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 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:	

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:

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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:		
Change the child's name? If so, enter the full new name.		

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 this parent deceased?	If yes, date:
First Name:		
Middle Name:		
Last Name:		
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

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<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

If birth parent and birth father were married, date of marriage: _____ Date of divorce: _____

Custody determination: _____ Case No. (if known): _____

Address:		County: <input type="checkbox"/>	<input type="checkbox"/>
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:		<input type="checkbox"/>	<input type="checkbox"/>
Is the parent a member of the military service on active duty?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Additional info add here:			

When complete, please save this PDF to your computer and attach it as an email to:

denise@peopleparalegal.com