

Please type or print all answers

APPLICATION FOR MATERNITY SERVICES

**LOUISIANA BAPTIST CHILDREN’S HOME
SELLERS MATERNITY MINISTRIES**

13758 DENHAM ROAD
BATON ROUGE, LA 70818
TELEPHONE: (225) 261-8886
Fax: (225)261-6133

Date of Application: _____

Social Security Number: _____

Name _____
Last Name First Name Middle Name

Address _____
Street and Number

City County/Parish State Zip Code

Telephone Number _____ Cell Number _____
Area Code Area Code

Alternate Number _____ Birthdate _____ Age _____ Race _____
Area Code

Birthplace _____
City County/Parish State

Please bring certified copy of your BIRTH CERTIFICATE

Where do you live now? Parents Other Family Member Alone Friend
Boyfriend Other _____

Services Requested: Maternity Home Counseling Outpatient Services
Adoptive Placement for Child Undecided Other _____

Who will be responsible for maternity expenses? _____

Does alleged father of your child know that you are pregnant? Yes No Don't Know
Comment: _____

Does alleged father know that you are planning to go to a maternity home? Yes No Don't Know

Race of father of child _____ Marital Status of father of child _____

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/death certificate 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

5) Graduate Work 1 2 3 4

DEGREE: _____ in _____
Area

Present Occupation: _____

Previous Occupation: _____

Hobbies, Interests: _____

How did you learn about this ministry?

Pastor Friend
Physician Other _____
Attorney

Has pregnancy been confirmed? Yes No If yes, by whom? _____

Have you received prenatal care? Yes No

If yes, please give due date and describe complications: _____

Physician's Name: _____ Address: _____

Phone Number: _____
Area code City/State Zip Code

MEDICAL DATA

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

Do you have any physical handicap? Yes No

If so, please specify: _____

Are you taking any medication? Yes No If yes, please list types and dosage: _____

Have you ever been treated for an emotional or mental disorder? Yes No

Have you ever been treated for alcohol or drug abuse? Yes No

May we contact the hospital, agency or physician who treated you? Yes No

Have you ever been arrested? Yes No If so, please specify: _____

Have you ever had any serious illness? Yes No If so, please specify: _____

Do you have any debts or financial obligations? Yes No If so, please specify: _____

Have you ever had an allergic reaction to anything? _____

Food allergies? Yes No Describe: _____

Medication allergies? Yes No Describe: _____

Environmental allergies? Yes No Describe: _____

Please tell us how we can best help you during the next few months.

Please mail the application with the documents given on the "List of Required Documents" Form.

To return Application Packet by Mail:

**SELLERS MATERNITY MINISTRIES
13758 DENHAM ROAD
BATON ROUGE, LA 70818**

To return Application Packet by Fax:

225-261-6133