

# family adoption center

1201 Allegheny Tower, 625 Stanwix Street, Pittsburgh, PA 15222  
(412) 288-2138

Tab 4

## BACKGROUND INFORMATION FORM: FAMILY STUDY APPLICATION

(Please type or print legibly)

Date received 9/29/97  
at agency \_\_\_\_\_

Full Name (H) MATTHEW A. MANCUSO  
 (W) \_\_\_\_\_ (DIVORCED)  
 Address 158 SHEARER ROAD Name of Community PLUM BORO  
NEW KENSINGTON 15068 County ALLEGH.  
 Phone Home: ( ) 335-7189 Work: (H) ( ) \_\_\_\_\_ (W) ( ) \_\_\_\_\_  
 Rent or own residence OWN Referred by THREE RIVERS ADO. COUNCIL  
 Age (H) 39 (W) \_\_\_\_\_ Date of birth: (H) 03JUL58 (W) \_\_\_\_\_

Employment history for the past five years listing current or last employer first:

(H) Employer <u>KEIBLER INDUSTRIES INC</u>	(W) Employer _____
Position <u>VP ENGINEERING/SALES</u>	Position _____
Dates <u>1974 - PRESENT</u>	Dates _____
Employer _____	Employer _____
Position _____	Position _____
Dates _____	Dates _____
Employer _____	Employer _____
Position _____	Position _____
Dates _____	Dates _____

Continue on other side of page if necessary

Highest educational level obtained: (H) B.S. ENGINEERING (W) \_\_\_\_\_  
 Date of Marriage \_\_\_\_\_ Length of infertility(if applicable) \_\_\_\_\_  
 Name of Physician \_\_\_\_\_  
 Previously married? (H) Yes X No \_\_\_\_\_ (W) Yes \_\_\_\_\_ No \_\_\_\_\_  
 If previously married, how long? (H) 11 YRS (W) \_\_\_\_\_  
 How was the marriage terminated? (H) DIVORCE (W) \_\_\_\_\_

I. Past Medical Treatment: Wife (If Applicable)

A. Past Treatment

1. What specific diagnostic and treatment methods have been tried in your infertility investigation?

<u>Date</u>	<u>Physician</u>	<u>Diagnosis</u>
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____
d. _____	_____	_____
e. _____	_____	_____
f. _____	_____	_____
g. _____	_____	_____
h. _____	_____	_____
i. _____	_____	_____
j. _____	_____	_____

2. Where does your infertility investigation stand now? Who is your current physician?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. List all the significant medical problems for which you have received treatment.

<u>Date</u>	<u>Physician</u>	<u>Diagnosis</u>
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____
d. _____	_____	_____
e. _____	_____	_____
f. _____	_____	_____
g. _____	_____	_____

II. Past Medical Treatment: Husband (If Applicable)

A. Past Treatment

NONE

1. What specific diagnostic and treatment methods have been tried in your infertility investigation?

	<u>Date</u>	<u>Physician</u>	<u>Diagnosis</u>
a.	_____	_____	_____
b.	_____	_____	_____
c.	_____	_____	_____
d.	_____	_____	_____
e.	_____	_____	_____
f.	_____	_____	_____
g.	_____	_____	_____
h.	_____	_____	_____
i.	_____	_____	_____
j.	_____	_____	_____

2. Where does your infertility investigation stand now? Who is your current physician?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. List all the significant medical problems for which you have received treatment.

	<u>Date</u>	<u>Physician</u>	<u>Diagnosis</u>
a.	_____	_____	_____
b.	_____	_____	_____
c.	_____	_____	_____
d.	_____	_____	_____
e.	_____	_____	_____
f.	_____	_____	_____
g.	_____	_____	_____

III. Past Mental Health Treatment: Wife

A. Have you ever had any type of mental health counseling? Yes \_\_\_\_\_ No \_\_\_\_\_

<u>Date</u>	<u>Type of problem addressed</u>	<u>Name of psychiatrist/counselor</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. Are you currently receiving mental health counseling? Yes \_\_\_\_\_ No \_\_\_\_\_

<u>Date</u>	<u>Type of problem addressed</u>	<u>Name of psychiatrist/counselor</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

C. Have you ever received medication for emotional problems? Yes \_\_\_\_\_ No \_\_\_\_\_

<u>Date</u>	<u>Name of medication</u>	<u>Dosage</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. Past Mental Health Treatment: Husband

A. Have you ever had any type of mental health counseling? Yes \_\_\_\_\_ No \_\_\_\_\_

<u>Date</u>	<u>Type of problem addressed</u>	<u>Name of psychiatrist/counselor</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. Past Mental Health Treatment: Husband (continued)

B. Are you currently receiving mental health counseling? Yes \_\_\_\_\_ No X

Date	Type of problem addressed	Name of psychiatrist/counselor
_____	_____	_____
_____	_____	_____
_____	_____	_____

C. Have you ever received medication for emotional problems? Yes \_\_\_\_\_ No X

Date	Name of medication	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

V. Adoption Investigation

What (if any) steps have you taken to investigate adopting? Include the dates, the activity, and with whom.

- 2.7.17.17  
THE PAST  
4 MONTHS*
1. EXTENSIVE RESEARCH ON THE INTERNET.  
(WEBSITES AND NEWS GROUPS.)  
TALK WITH FRIENDS WHO HAVE ADOPTED.
  2. HAVE CORRESPONDED BY EMAIL TO FAMILIES  
THAT HAVE ADOPTED / ARE ADOPTING.  
(PRIMARILY TO GET INFO OF INTERNATIONAL ADOPTION)
  3. TELEPHONE CONVERSATIONS AND INFORMATION  
PAMPHLETS FROM DIFFERENT AGENCIES
  4. TELEPHONE CONVERSATIONS TO CHECK AGENCY  
REFERENCES.
  5. VISITATION OF LOCAL DAY CARE CENTERS TO  
INVESTIGATE SERVICES + POLICY.

## VI. Current Adoption Situation.

Please discuss your current adoption situation. Is it a private or agency adoption (foreign or domestic; local or out of state placement, etc.)

If an agency, please list name, address, phone number, contact person, etc. If not, please list the attorney involved with the placement.

FAMILIES THROUGH INTERNATIONAL ADOPTION  
 CHERRY HILL, NJ.  
 JEANNENE SMITH  
 Ph: 609-321-0777  
 Fax: 609-321-0809

I AM WORKING WITH JEANNENE IN THEIR CHILDREN OF RUSSIA PROGRAM. I HAVE BEEN TALKING WITH JEANNENE (AND HANNA) FOR ABOUT A MONTH AND HAVE JUST RECENTLY SENT THEM MY FORMAL APPLICATION.

I HAVE TALKED TO OTHER FAMILIES THAT HAVE WORKED WITH JEANNENE. - ALL HAVE BEEN VERY POSITIVE.

10/2/97 I called Jeannene Smith & confirmed Matt's assessment client. He can adopt as a single parent. She is sending agency information to me.

N Simpson ACSW/CW