



(Rev. 2/04/09)

Adoption Application

Home Office:

11780 Borman Dr.
St. Louis, MO 63146
314.890.0086 Phone

www.ChildrensHope.net
Adoption@ChildrensHope.net
314.427.4288 Fax

SECTION 1 – FIRST STEP ON A JOURNEY OF LOVE

- Type or Print CLEARLY in ink.
- If a question does not apply to your family, use "N/A".
- If you need additional space, please attach a separate sheet of paper.
- This application is confidential and used for **internal** purposes only.
- Please allow 2 weeks for review of this application.
- You must allow 1 year after a life changing event before applying (marriage, divorce, death)
- You can apply to adopt 6 months after the birth or adoption of a child but have to wait for the 1 year mark before sending in your dossier.
- Please include the following with your completed application:
 1. **\$100 check** (non-refundable) to **Children's Hope International** for application fee.
 2. **Photos:** No larger than 4 x 6 photos. Two (2) – Different, Non-professional, close-up (head and shoulders w/o sunglasses or hats) photos of adoptive couple together or the single parent; One (1) – Other children in home; One (1) – Exterior photo of house; Three(3) – Interior photos of house – choose three different rooms. Please write family name on back of pictures. **Pictures are non-returnable.**

SECTION 2 – CONTACT INFORMATION

Ms. Mrs. _____
Legal First Name Legal Middle Name Legal Last Name

Mr. _____
Legal First Name Legal Middle Name Legal Last Name

Mother's Preferred or Nick Name Father's Preferred or Nick Name

Street Apt/Unit No.

City State Zip Code

(____) _____ - _____ (____) _____ - _____ (____) _____ - _____
Home Number Work Number - Mother Work Number - Father

(____) _____ - _____ (____) _____ - _____ (____) _____ - _____
Fax Number Mobile Number - Mother Mobile Number - Father

PLEASE CIRCLE PREFERRED NUMBER(S) TO BE CONTACTED

Primary E-mail Address (Mom Dad Both Hm Wk)

Secondary E-mail Address (Mom Dad Both Hm Wk)

FOR OFFICE USE ONLY

Country _____

Processed By _____

Date _____

Regional Office _____

Reviewed By _____

Date _____

Check No. _____

Approved By _____

Date _____

SECTION 5 – ADOPTION INFORMATION

1. Do you have known or expected infertility? _____
2. Are you pregnant? _____
3. Are you currently working on another adoption besides this application? _____
4. Have you ever been turned down for adoption by another agency? _____
5. Please state what country you have chosen to adopt in _____ and why?

6. Why do you want to adopt? _____
7. What is your preference regarding the child you want to adopt? (*please check all that apply*)
Age: _____ Months Years
Sex: Male Female Either Siblings
Comments: _____
Note: CIS will require that you immunize your adopted child within 30 days of returning home.
8. If adopting trans-racially, do you have any concerns you would like to discuss? _____

9. Are you applying to adopt a child with special needs? _____
10. If you have been pre-approved for a Waiting Child, please provide:
Child's Name: _____ Reference # _____

SECTION 6 – HOME STUDY / AND / IMMIGRATION AND NATURALIZATION

(IF YOU LIVE IN MO CHI WILL DO YOUR HOMESTUDY)

1. Do you have a social worker connected with an agency to do your home study? Yes No

If yes, Name of Agency: _____

City:	State:	Zip:
Contact:	Tel: ()	Fax: ()
Completed?	In Progress?	Expected completion?

SECTION 7 – HEALTH INFORMATION

Mother's Health: Excellent Good Fair Poor **Father's Health:** Excellent Good Fair Poor
 If you answer **yes** to any of the below, please provide (**full details & dates, past or present**). Please use another sheet if needed. **IF YOU LIST ANY MEDICAL ISSUES OR MENTAL HEALTH ISSUES, PLEASE PROVIDE A LETTER FROM DOCTOR.** (*Other than tonsils, appendix, dental, vision, cosmetic, pregnancy, allergies*)

	Mother	Father
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tumor (non-cancerous)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neuropathy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Genetic Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any Operations*	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes:		
Type I	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type II	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Impairments:		
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mobility	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Communicable Diseases:		
Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis C	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Illness:		
Bi-Polar Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eating Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Counseling/Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medical Issue 1 Mother Father

Condition _____
 Date of Diagnosis _____
 Treatment Received _____
 Prognosis/Outcome _____
 Ongoing Treatment, if any _____
 Medication, if any _____

Medical Issue 2 Mother Father

Condition _____
 Date of Diagnosis _____
 Treatment Received _____
 Prognosis/Outcome _____
 Ongoing Treatment, if any _____
 Medication, if any _____

Medical Issue 3 Mother Father

Condition _____
 Date of Diagnosis _____
 Treatment Received _____
 Prognosis/Outcome _____
 Ongoing Treatment, if any _____
 Medication, if any _____

* *Other than tonsils, appendix, dental, vision, cosmetic, pregnancy, etc.*

1. Mother – Height _____ Weight _____ Father – Height _____ Weight _____

2. Are you taking any medications? _____ If yes, see below.

- | | | | |
|--------------------|---------------|---------------------------------|---------------------------------|
| 1. Medicine: _____ | Reason: _____ | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| 2. Medicine: _____ | Reason: _____ | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| 3. Medicine: _____ | Reason: _____ | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| 4. Medicine: _____ | Reason: _____ | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| 5. Medicine: _____ | Reason: _____ | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |

3. Does the health insurance cover the adopted child? _____

SECTION 8 - POLICE RECORD

Have you ever been **arrested, charged or convicted** of any crimes, **including but not limited to**, shoplifting, fraud, theft, prostitution, solicitation, DUI, DWI, domestic violence, child abuse, assault, or possession of a controlled substance? (Regardless if expunged, record sealed, etc.)

Mother _____ **Father** _____

*If you answered "yes" to the question above, please provide additional information: **Also state whether it is a misdemeanor or felony. You must attached court disposition & criminal record check***

	Arrest/Conviction 1 <input type="checkbox"/> Mother <input type="checkbox"/> Father	Arrest/Conviction 2 <input type="checkbox"/> Mother <input type="checkbox"/> Father	Arrest/Conviction 3 <input type="checkbox"/> Mother <input type="checkbox"/> Father
Charge			
Year it occurred			
Dismissed/Guilty/Probation/Not Guilty, etc			
Fine/Probation/Jail, etc.			
Time spent in jail, if any			
Type & length of probation			

Please provide additional information, use separate sheet if needed:

SECTION 9 – FINANCIAL INFORMATION

	Mother	Father
Employer & Length of Employment Position:	_____	_____
Annual Income:	\$ _____	\$ _____
Other Annual Income:	\$ _____	\$ _____

1. Total Assets (vehicles, personal property, value of home, stocks/bonds, checking/savings, etc.) \$ _____
2. Indebtedness (including mortgage, credit cards auto payments & other) \$ _____
3. Do you own or rent your home/apartment? _____
4. Have you ever filed bankruptcy? _____ When? _____

SECTION 10 – COMMENTS / HOW DID YOU HEAR ABOUT CHILDREN'S HOPE?

1. How did you hear about our agency? (check all that apply)

Word of Mouth:

- CHI Adoptive Family Other Adoptive Family Friend Relative Co-Worker Other
 Internet search:

2. Have you talked with or worked with a staff person other than in St. Louis? _____

3. Aside from workshops and individual meetings, _____ contacted/assisted me by: Phone E-mail Letter Information Meeting

5. Assistance provided by the Outreach Consultant influenced my decision to choose CHI?
 Yes No

6. *Very Important:* Name of person that contacted me and assisted me with the decision to make this application: Marianne Adams Nikki DeSimone Jill Imperato Jennifer Chavis
 Julie Fischer Other _____

7. Or were you in touch with only the St. Louis office? _____

SECTION 11 – EMERGENCY CONTACT INFORMATION

	Emergency Contact 1	Emergency Contact 2
Name	_____	_____
Relationship	_____	_____
Phone Number	_____	_____
Email Address	_____	_____

SECTION 12 – STATEMENT OF AGREEMENT AND SIGNATURE

I/We understand:

- That there are risks in adoption and realize that a target country has the power and authority to close its doors to adoption if they should so decide.
- That information on health and all other matters on the adoptive child received through CHI is limited, and based on all available data sent by adoption officials in the foreign country.
- Should I/We travel to the foreign country and decide not to continue with the adoption after making final agreement to do so, CHI will not be held responsible for the ultimate decision of the officials in the adoptive country or for financial loss that you may have incurred to that point.
- **That you agree not to pursue another adoption or plan a pregnancy. If an unplanned pregnancy should occur, you will inform CHI immediately and CHI will determine how to proceed.**
- ***Failure to fully disclose all information requested on this application may effect the outcome of the adoption and may result in the closure of your file.***

I/WE HEREBY CERTIFY BY SIGNING BELOW, GIVE CONSENT AND AGREEMENT TO THE ABOVE AND THAT ALL INFORMATION GIVEN IN THIS APPLICATION IS CORRECT TO THE BEST OF MY/OUR KNOWLEDGE AND ABILITY.

X

Date: _____

X

Date: _____

THIS APPLICATION IS GOOD FOR ONE YEAR FROM THE DATE OF YOUR SIGNATURE. IF YOUR NAME IS NOT ON THE PROGRAM DOSSIER LIST WITHIN THIS YEAR, THEN YOU NEED TO SUBMIT A NEW APPLICATION AND PAY THE CURRENT YEAR'S FEES.



HAGUE ACCREDITED

PLEASE RETURN THIS APPLICATION TO

Children's Hope International

11780 Borman Drive

St. Louis, MO 63146