

SECTION 3 – GENERAL INFORMATION

	Mother	Father
SSN	_____	_____
Passport #	_____ (if available)	_____ (if available)
Birth Date:	_____ (MM/DD/YY) Age _____	_____ (MM/DD/YY) Age _____
Citizenship*:	_____	_____
Race: (optional)	_____	_____
Religion:	_____	_____
Education:	_____	_____
Maiden Name:	_____	N/A
Country Born in	_____	_____

*At least one parent must be a U.S. Citizen

SECTION 4 – MARITAL INFORMATION

- Married
 Divorced
 Single (Never Married)
 Widowed

- If married, date of marriage: _____ (must be married at least 1 year before application can be accepted)
- Are there previous marriages? _____ If yes, see below. Divorces? _____ (no more than 2 divorces per parent)

Mother		Father	
1. Marriage date:	Divorce date:	1. Marriage date:	Divorce date:
2. Marriage date:	Divorce date:	2. Marriage date:	Divorce date:

- If you have children, please list below:

Child's Name	Age	Biological / Adopted	Living Arrangements/Date Adopted	Is he/she from previous marriage?
1.				
2.				
3.				
4.				
5.				
6.				

- Are your children immunized? _____
- Have you ever terminated your parental rights of a biological or adopted child? _____
(If yes, please explain on a separate sheet)
- Are there other people living in your home? _____ If yes, please list their names and ages: _____
- What is their relationship to you? _____

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 AR, MO, IL, KS, NY, TN, TX, OR, or WA, 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**. 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
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

1. 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.***

	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. Please tell us why you chose CHI: _____

2. 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: Google Yahoo MSN Adoption.com Other _____

Television: News Story Yellow Pages

Newspaper: Ad News Story

Magazine: Ad Article

Radio

Flyer / Church Bulletin

Social Worker / Home Study Agency _____

Infertility or Adoption Support Group _____

Adoption Conference _____

Other _____

3. Have you met with staff of a CHI Regional Office?

Workshop _____ Individual Meeting _____ Did not meet

4. Aside from workshops and individual meetings, the Regional Office contacted/assisted me by:

Phone E-mail Letter Information Meeting

5. Assistance provided by the Regional Office influenced my decision to choose CHI? Yes No

6. Location of Regional Office that assisted me: _____

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.

PLEASE RETURN THIS APPLICATION TO

**CHILDREN'S HOPE INTERNATIONAL
11780 BORMAN DRIVE
ST. LOUIS, MO 63146**

OR

THE CHILDREN'S HOPE REGIONAL OFFICE IN YOUR AREA