

## ADOPTION PROGRAM APPLICATION

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DATE: \_\_\_\_\_ INTERNATIONAL \_\_\_\_\_  
DOMESTIC \_\_\_\_\_  
HOME STUDY ONLY \_\_\_\_\_

IDENTIFYING INFORMATION:

HUSBAND: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
SOC. SEC. #: \_\_\_\_\_ AGE: \_\_\_\_\_  
U.S. CITIZEN: YES \_\_\_ NO \_\_\_ WORK PHONE: \_\_\_\_\_

WIFE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
SOC. SEC. #: \_\_\_\_\_ AGE: \_\_\_\_\_  
U.S. CITIZEN: YES \_\_\_ NO \_\_\_ WORK PHONE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
\_\_\_\_\_

COUNTY OF RESIDENCE: \_\_\_\_\_ LENGTH OF RESIDENCE \_\_\_\_\_  
DATE OF MARRIAGE: \_\_\_\_\_ PLACE: \_\_\_\_\_

CHILDREN LIVING IN THE HOME (include adult children):

FULL NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
FULL NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

CHILDREN NOT LIVING IN THE HOME:

FULL NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
FULL NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

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NAME AND AGE OF ANY OTHER ADULTS (OVER AGE 18) LIVING IN THE HOME AND THEIR RELATIONSHIP TO YOU:

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

PRIOR MARRIAGE(S): (PLEASE LIST NAME(S) OF PRIOR SPOUSES AND DATE OF DIVORCE):

HUSBAND: \_\_\_\_\_

WIFE: \_\_\_\_\_

ARE YOU UNDER ANY LEGAL OBLIGATION TO PAY CHILD SUPPORT? \_\_\_\_\_  
IF YES, ARE YOU UP TO DATE ON MAKING YOUR PAYMENTS: \_\_\_\_\_

EMPLOYMENT: (HUSBAND)

EMPLOYER \_\_\_\_\_ ADDRESS: \_\_\_\_\_

LENGTH OF EMPLOYMENT: \_\_\_\_\_ POSITION HELD: \_\_\_\_\_

ANNUAL SALARY: \_\_\_\_\_ OTHER INCOME: \_\_\_\_\_

EMPLOYMENT: (WIFE)

EMPLOYER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

LENGTH OF EMPLOYMENT: \_\_\_\_\_ POSITION HELD: \_\_\_\_\_

ANNUAL SALARY: \_\_\_\_\_ OTHER INCOME: \_\_\_\_\_

EDUCATION: PLEASE LIST HIGHEST DEGREE, YEAR OBTAINED, AND INSTITUTION.

HUSBAND: \_\_\_\_\_

WIFE: \_\_\_\_\_

PHYSICAL:

HUSBAND:

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ HAIR COLOR \_\_\_\_\_ EYE COLOR \_\_\_\_\_

RELIGION \_\_\_\_\_ RACE \_\_\_\_\_

WIFE:

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ HAIR COLOR \_\_\_\_\_ EYE COLOR \_\_\_\_\_

RELIGION \_\_\_\_\_ RACE \_\_\_\_\_

EXTENDED FAMILY INFORMATION:

HUSBAND'S FAMILY: (PLEASE INCLUDE AGE, MARITAL STATUS,  
OCCUPATION AND ADDRESS OF ALL FAMILY MEMBERS)

MOTHER \_\_\_\_\_

FATHER \_\_\_\_\_

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(address)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SIBLINGS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Use back of application if more space is needed)

WIFE'S FAMILY: (PLEASE INCLUDE AGE, MARITAL STATUS, OCCUPATION,  
AND ADDRESS OF ALL FAMILY MEMBERS)

MOTHER \_\_\_\_\_

FATHER \_\_\_\_\_

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(address)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SIBLINGS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Use back of application if more space is needed)

HEALTH:

PLEASE PRINT CLEARLY THE NAMES OF THE PHYSICIAN(S) WHO WILL COMPLETE THE MEDICAL EXAMINATIONS FOR YOUR HOMESTUDY:

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

HAVE YOU BEEN TREATED, OR ARE YOU BEING TREATED, BY A PHYSICIAN FOR ANY CONDITION(S)? IF YES, PLEASE DESCRIBE:

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

PLEASE DESCRIBE ANY HOSPITALIZATIONS WITHIN THE LAST TEN YEARS:

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

HAVE YOU EVERY BEEN ARRESTED (EVEN IF EXPUNGED), CHARGED WITH A CRIME, CONVICTED OF A CRIME, SERVED ANY TIME IN JAIL OR PRISON, OR BEEN THE SUBJECT OF A CHILD ABUSE AND/OR CHILD NEGLECT INVESTIGATION (EVEN IF IT WAS ULTIMATELY CONSIDERED UNFOUNDED OR DID NOT RESULT IN AN ARREST)? IF YES TO ANY OF THE ABOVE, PLEASE DESCRIBE.

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

HAVE YOU EVER BEEN REFERRED TO, EVALUATED BY OR RECEIVED TREATMENT FROM, OR ARE YOU CURRENTLY RECEIVING TREATMENT FROM ANY KIND OF MENTAL HEALTH PROFESSIONAL? IF YES, PLEASE EXPLAIN.

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HAVE YOU EVER BEEN REFERRED TO, EVALUATED BY OR RECEIVED TREATMENT FROM, OR ARE YOU CURRENTLY RECEIVING TREATMENT FROM A DRUG OR ALCOHOL TREATMENT/REHABILITATION PROGRAM? IF YES, PLEASE EXPLAIN.

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HAVE YOU EVER FILED FOR BANKRUPTCY? IF YES, PLEASE SAY WHEN IT WAS AND DESCRIBE THE SITUATION AND OUTCOME.

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LIFE INSURANCE:            KIND:                    AMOUNT:                    BENEFICIARY:

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HEALTH INSURANCE:

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ARE YOU CURRENTLY WORKING WITH ANY OTHER AGENCIES? PLEASE LIST.

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ADOPTION PLANS:

WHY ARE YOU CONSIDERING ADOPTION AT THIS TIME?

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HAVE YOU PREVIOUSLY ADOPTED? IF YES, PLEASE EXPLAIN. HAS THE ADOPTION BEEN FINALIZED OR REFINALIZED AND, IF SO, WHEN?

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LIST ANY ADOPTION-RELATED CLASSES THAT YOU HAVE ATTENDED OR READING THAT YOU HAVE DONE TO PREPARE FOR YOUR ADOPTION.

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IF YOU HAVE ANY PREFERENCES, PLEASE DESCRIBE THE AGE RANGE, GENDER AND ANY RACIAL AND/OR PHYSICAL CHARACTERISTICS OF THE CHILD YOU ARE INTERESTED IN ADOPTING. IF YOU ARE ADOPTING INTERNATIONALLY, HAVE YOU DECIDED ON THE COUNTRY?

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WOULD YOU CONSIDER ADOPTING A CHILD WITH SPECIAL NEEDS? IF YES, WHAT SPECIAL NEEDS WOULD YOU CONSIDER?

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LEGAL GUARDIANS OF ADOPTED CHILD: (LIST NAME, ADDRESS, AGE, OCCUPATION AND RELATIONSHIP TO YOU OF THE PERSON(S) WHO YOU WOULD APPOINT AS YOUR CHILD'S LEGAL GUARDIAN, IF THE NEED AROSE)

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REFERENCES: PLEASE LIST THREE PEOPLE WHO YOU WOULD USE AS REFERENCES. THEY SHOULD BE PEOPLE WHO KNOW YOU WELL, FOR AT LEAST TWO YEARS (NOT RELATIVES, CLERGY OR ANYONE EMPLOYED BY YOU). PLEASE INCLUDE THEIR ADDRESS AND A TELEPHONE NUMBER WHERE THEY CAN BE REACHED (PLEASE INDICATE IF IT IS A HOME OR WORK NUMBER).

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PLEASE PROVIDE US WITH DIRECTIONS TO YOUR HOUSE FROM OUR OFFICE IN RANDALLSTOWN, MD, LOCATED ON LIBERTY ROAD, OFF EXIT 18 OF 695, THE BALTIMORE BELTWAY.

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HOW DID YOU HEAR ABOUT BOARD OF CHILD CARE? \_\_\_\_\_

YOUR E-MAIL ADDRESS (OPTIONAL - PROVIDE IF YOU WOULD LIKE, AT TIMES, TO CORRESPOND BY E-MAIL) \_\_\_\_\_



