



RECEIVED ON _____

**ADOPTION APPLICATION
FOR ADOPTION CHOICES OF COLORADO**

Application fee is \$650.00 made out to Adoption Choices and must accompany application. This fee is non-refundable.

(All information will remain confidential unless your permission is granted, in writing, to release part or parts of it.)

Please remember that with the new age of technology and the internet, your name, address and phone number can possibly be located through diligence by a birth parent. Please note, most of the correspondence, on our part, will be through email.

Please check one of the following boxes:

- Domestic Home Study Only
- Domestic Home Study and Matching (A Non-refundable Matching Fee of \$2,500 is required prior to matching)
- Domestic Matching Only (A Non-refundable Matching Fee of \$2,500 is required prior to matching)

First Applicant's Full Name: _____

Second Applicant's Full Name: _____

Home Street Address: _____

Home City, State and Zip Code: _____

County of Residence: _____

Home Phone Number: _____

First Applicant's Cell Phone Number: _____

Second Applicant's Cell Phone Number: _____

First Applicant's Email Address: _____

Second Applicant's Email Address: _____

States in which you have resided in the last 5 years

First Applicant: _____

Second Applicant: _____

PERSONAL INFORMATION

How did you hear about our agency? _____

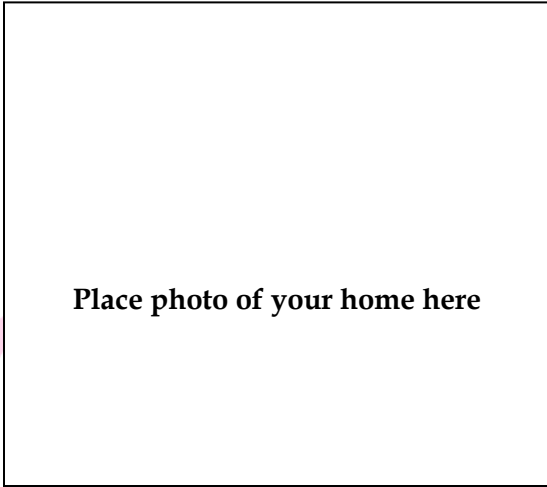
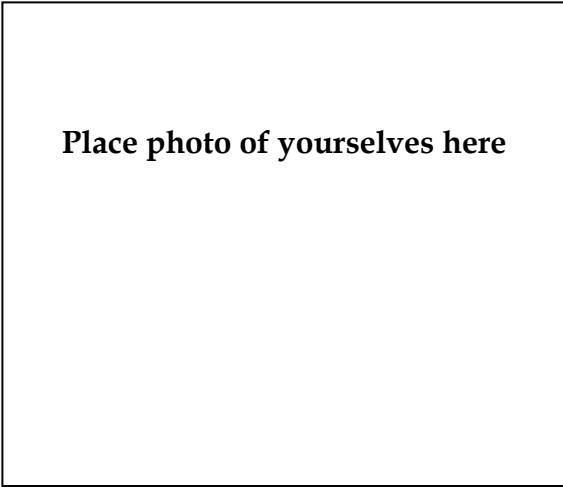
Date and place of marriage (if applicable): _____

Names, birth dates and ages of children (if applicable). State whether adopted or biological and if they reside in your home: _____

Any other household members names, date of birth and ages: _____

**Anyone living in your home who is 18 years or older, is required to provide CBI and FBI Clearance, Child Abuse Clearance, Physician's Report, Sex Offender Clearance, and to meet with the case worker





FIRST APPLICANT

Date of birth & age: _____
Place of birth: _____
Social Security Number: _____
Maiden/Other names previously used: _____
Race/Nationality: _____
Weight ,Height, Hair and Eye Color: _____
Education: _____
Occupation: _____
Employer name & for how long: _____
Office Address: _____
Office Phone Number: _____
Work Email: _____
Annual Income: _____
Religious preference: _____
Dates of previous marriages & divorces: _____
All Children (ages and custody status): _____

Who is your health insurance provider? _____
Do you have life insurance? If yes, how much? _____
Have you ever served in the military? _____
Are you enrolled or eligible for enrollment in any Native American Tribe? If yes, what
tribe: _____
Driver's License # and Expiration Date: _____

SECOND APPLICANT

Date of birth & age: _____
Place of birth: _____
Social Security Number: _____
Maiden/Other names previously used: _____
Race/Nationality: _____
Weight, Height, Hair & Eye Color: _____
Education: _____
Occupation: _____
Employer name & for how long: _____
Office Address: _____
Office Phone Number: _____
Work Email: _____
Annual Income: _____
Religious preference: _____
Dates of previous marriages & divorces: _____
All Children (ages and custody status): _____

Who is your health insurance provider? _____
Do you have life insurance? If yes, how much? _____
Have you ever served in the military? _____
Are you enrolled or eligible for enrollment in any Native American Tribe? If yes, what
tribe: _____
Driver's License # and Expiration Date: _____

FAMILY BACKGROUND

FIRST APPLICANT

Father's name & age: _____
Address: _____
Phone Number: _____
Occupation: _____
Marital status & spouse's name: _____

Mother's name & age: _____
Address: _____
Phone number: _____
Occupation: _____

Sibling's name & age: _____
Address: _____
Phone number: _____

Occupation: _____
Marital status & spouse's name: _____
Names and ages of children: _____

Sibling's name & age: _____
Address: _____
Phone number: _____
Occupation: _____
Marital status & spouse's name: _____
Names and ages of children: _____

Sibling's name & age: _____
Address: _____
Phone number: _____
Occupation: _____
Marital status & spouse's name: _____
Names and ages of children: _____

Sibling's name & age: _____
Address: _____
Phone number: _____
Occupation: _____
Marital status & spouse's name: _____
Names and ages of children: _____

SECOND APPLICANT

Father's name & age: _____
Address: _____
Phone Number: _____
Occupation: _____

Mother's name & age: _____
Address: _____
Phone number: _____
Occupation: _____

Sibling's name & age: _____
Address: _____
Phone number: _____
Occupation: _____
Marital status & spouse's name: _____
Names and ages of children: _____

Sibling's name & age: _____
Address: _____
Phone number: _____
Occupation: _____
Marital status & spouse's name: _____
Names and ages of children: _____

Sibling's name & age: _____
Address: _____
Phone number: _____
Occupation: _____
Marital status & spouse's name: _____
Names and ages of children: _____

Sibling's name & age: _____
Address: _____
Phone number: _____
Occupation: _____
Marital status & spouse's name: _____
Names and ages of children: _____

PHYSICAL/MENTAL HEALTH HISTORY

FIRST APPLICANT

Medical conditions (past & present): _____
Psychiatric history (past & present): _____
Drug or alcohol issues (past & present): _____

SECOND APPLICANT

Medical conditions (past & present): _____
Psychiatric history (past & present): _____
Drug or alcohol issues (past & present): _____

YOUR HOME

Do you own or rent your home? _____
If you own your home, what is the value of it? _____

Mortgage left on owned home: _____
Monthly rent or house payment: _____

REFERENCES - In-State Applicants Only

Please list three (3), non-relative references who our agency may contact for a reference. We will mail or email them a form.

Name: _____
Full Address: _____
Phone number: _____
Email address: _____

Name: _____
Full Address: _____
Phone number: _____
Email address: _____

Name: _____
Full Address: _____
Phone number: _____
Email address: _____

INFORMATION ON CHILD YOU WISH TO ADOPT

Gender & age preference: _____

Nationality you would accept (please check all that apply)

Caucasian:	_____	Caucasian/Hispanic:	_____
Hispanic:	_____	Caucasian/African American:	_____
African American:	_____	Caucasian/Asian:	_____
Asian:	_____	Caucasian/Hawaiian:	_____
Hawaiian:	_____	Caucasian/Pacific Island:	_____
Native American:	_____		

Would you accept:

Twins: _____
An older child: _____ Up to what age? _____
More than one older child if they were siblings? _____
A child with a correctable medical condition? _____

OPENNESS IN YOUR ADOPTION

INDICATE
YES NO MAYBE

Openness in Your Adoption

Would you accept a semi-open adoption where the agency would present your profile to the birth mother and you would meet the birth parent(s) prior to placement. Your first names only would be provided to the birth parent(s) unless you choose to share more information. (For example, with the introduction of the internet, a birth parent who knows your first name, your profession and the state in which you live could easily find you through the internet or other technological means.)

Would you accept an open adoption, where the birth parents would periodically meet and visit with the child after placement and the adoption is final?

Indicate your level of acceptance of a child who has the following problems:

INDICATE
YES NO MAYBE

NEWBORNS

A. Low APGAR score, prognosis uncertain

DRUGS

Would you accept a child whose biological mother:

A. Is currently drug addicted?

B. Had previously used drugs?

C. Had previously been drug addicted?

D. Had used drugs before realizing she was pregnant?

E. whose biological father had used drugs at conception or was addicted to drugs during the pregnancy?

ALCOHOL

Would you accept a child whose biological mother:

A. Had abused alcohol, prognosis uncertain

B. Was presently using alcohol?

C. Is alcohol addicted?

D. Had previously been alcohol addicted but is not at time of conception?

E. Had used alcohol before realizing she was pregnant?

INDICATE
YES NO MAYBE

CHILDREN

- | | | | | |
|----|---------------------|--------------------------|--------------------------|--------------------------|
| A. | Slight limp | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. | Leg braces | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. | Missing limb | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. | Is in a wheel chair | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. | Is paraplegic | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. | Is quadriplegic | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. | Cerebral Palsy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. | Cystic Fibrosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SEIZURES

- | | | | | |
|----|---|--------------------------|--------------------------|--------------------------|
| A. | Seizure disorder controlled by medication | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. | Seizure disorder not controlled but has infrequent seizures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. | Seizure disorder not controlled and has frequent seizures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

BLOOD DISORDERS

- | | | | | |
|----|--|--------------------------|--------------------------|--------------------------|
| A. | Blood disorder requiring blood transfusions every 3 months | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. | Blood disorder requiring hospitalization once a month | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. | Blood disorder resulting in a limited lifespan | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

HEART PROBLEMS

- | | | | | |
|----|--|--------------------------|--------------------------|--------------------------|
| A. | Heart murmur, activity not curtailed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. | Heart murmur, vigorous activity curtailed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. | May require open heart surgery at a later date but at placement needs only to be monitored | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. | Definitely will require open heart surgery | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. | Will require more than one open heart surgery | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SIGHT PROBLEMS

- | | | | | |
|----|---|--------------------------|--------------------------|--------------------------|
| A. | Sight in both eyes but vision is limited/glasses needed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. | Sight in one eye only | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. | Blind but surgery may give partial sight | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. | Blind and will never have sight | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

HEARING PROBLEMS

- | | | | | |
|----|--|--------------------------|--------------------------|--------------------------|
| A. | Hearing problem with only partial hearing/surgery may help | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. | Hearing problem with partial hearing/surgery will not help | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. | Hearing in only one ear | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. | No hearing, deaf and does not speak | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

PHYSICAL DEFORMITIES

- | | | | | |
|----|---------------|--------------------------|--------------------------|--------------------------|
| A. | Deformed hand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. | Deformed arm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

		INDICATE		
		YES	NO	MAYBE
C.	Deformed leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.	Deformed face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E.	Two deformed arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F.	Two deformed legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SPECIAL NEEDS CHILDREN				
A.	In special education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.	In EMR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.	In TMR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.	Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HYPERACTIVE PROBLEMS (OLDER CHILDREN)				
A.	Hyperactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.	Hyperactive, requires medication/functions normally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.	Hyperactive, requires medication and some kind of special classroom setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EMOTIONAL PROBLEMS (OLDER CHILDREN)				
A.	Emotionally damaged, very withdrawn and will require therapy for an extensive period of time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.	So emotionally damaged he/she is very abusive toward other people; a child who is abusive to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.	Emotionally damaged; he/she is very abusive toward his/her person (pulling hair, pinching self)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SPEECH PROBLEMS (OLDER CHILDREN)				
A.	Stutters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.	Lisp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.	Speech is very hard to understand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.	Will always have trouble speaking and being understood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLEFT PROBLEMS (OLDER CHILDREN)				
A.	Hare lip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.	Cleft palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.	Both hare lip and cleft palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SICKLE CELL ANEMIA DISORDER (OLDER CHILDREN)				
A.	Sickle Cell carrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.	Sickle Cell Anemia but relatively controlled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.	Sickle Cell Anemia with frequent episodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BURNS (OLDER CHILDREN)				
A.	Burn scars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.	Slight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- | | | INDICATE | | |
|----|----------------------------|--------------------------|--------------------------|--------------------------|
| | | YES | NO | MAYBE |
| C. | Extensive, needing surgery | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

BIRTH MARKINGS (OLDER CHILDREN)

- | | | | | |
|----|--------------------|--------------------------|--------------------------|--------------------------|
| A. | Birth marks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. | Small | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. | Large or extensive | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

BI-POLAR DISORDER

- | | | | | |
|----|---|--------------------------|--------------------------|--------------------------|
| A. | Had one parent diagnosed with bi-polar disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. | Had both parents diagnosed with bi-polar disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. | Had grandparent(s) diagnosed with bi-polar disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. | Had one parent who was taking medication during pregnancy for bi-polar? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SCHIZOPHRENIA

- | | | | | |
|----|--|--------------------------|--------------------------|--------------------------|
| A. | Schizophrenic child | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. | Had one parent diagnosed as schizophrenic | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. | Had two parents diagnosed as schizophrenic | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. | Had grandparents diagnosed as schizophrenic? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

DEPRESSION

- | | | | | |
|----|---|--------------------------|--------------------------|--------------------------|
| A. | Had one parent who was depressed but not on medication? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. | Had two parents who were depressed but not on medication? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. | Had one parent who was depressed and on medication? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

HIV

- | | | | | |
|----|--------------------------------------|--------------------------|--------------------------|--------------------------|
| A. | Had one parent diagnosed with HIV? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. | Had both parents diagnosed with HIV? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

FINANCES

The cost of our adoptions generally range between \$35,000 and \$45,000, excluding finalization costs and any travel expenses. How much are you will and able to spend on an adoption, excluding finalization costs and travel expenses? _____

GENERAL QUESTIONS

Have you ever had an adoption fail or fall through? If so, please describe the circumstances: _____

Have you already had a home study done by anyone for the purpose of adoption? If yes, who did it and when? (please ask them to send our agency two (2) original copies)

Have you ever been denied a favorable home study? If yes, when and for what reason?

Are you using any other methods to try and adopt? _____

How long have you been in the adoption process? _____

Have you applied for a child elsewhere? If yes, when and where and what were the results? _____

If you reside outside of Colorado:

Name of Home Study Agency: _____

Address: _____

Contact Person, phone #, and e-mail: _____

Has your application been submitted to this agency & accepted? _____

Adoption Placement Agency (if not Adoption Choices of Colorado):

Name of Agency: _____

Contact Person, Phone #, and e-mail: _____

Has your application been submitted to this agency & accepted? _____

Past Foster Care or Foster/Adopt History

If you have ever been licensed as a foster care home or a foster/adopt home

Name of Agency: _____

Address: _____

Contact Person, phone # and e-mail: _____

Name of Agency: _____

Address: _____

Contact Person, phone # and e-mail: _____

Have you ever had any of the following.... If yes, please explain on a separate sheet of paper for each applicant. Indicating yes to any of these questions does not necessarily preclude you from adopting. But it is important to have this information in order to better assist you.

Declared bankruptcy or foreclosed on a home? _____

Are you currently or have you ever been under psychiatric care of a hospital? _____

*A chronic or life altering illness? _____

Been on anti-depressants or anti-anxiety medications? _____

Received dishonorable discharge from military service? _____

Relinquished your rights to a child or had your rights terminated? _____

Dissolved or disrupted a child's adoption? _____

Been convicted of any type of felony? _____

Been in treatment for alcohol or substance abuse? _____

Past due on any court ordered installment of child support? _____

Been denied by another adoption agency? _____

Had a child removed from your home or custodial care for any reason? _____

Been arrested for physical abuse, domestic abuse, child abuse or neglect, or sexual abuse? _____

Been investigated for any type of abuse? _____

Any history of any arrest, conviction, or other adverse criminal history, whether in the United States or abroad, even if the record of the arrest, conviction or other adverse criminal history has been expunged, sealed, pardoned or the subject of any amelioration? _____

Any history, either as a victim or perpetrator, of child abuse, child neglect, sexual abuse, or domestic violence, whether it resulted in an arrest or conviction or not? _____

Medically documented infertility? _____

Why do you wish to adopt a child? _____

Any other comments or information you would like to add:

**If you have a chronic or life altering illness, this information will be disclosed to birth parents prior to being selected for a match.*

Consent to E-mail or Text Usage for Agency Communications:

Clients of Adoption Choices of Colorado may be contacted via e-mail and/or text messaging to provide information relating to the agency, to provide general adoption information, and/or to obtain feedback on your experience with the agency. The client understands that once they have consented to receive communication via e-mail or text message, the client has the right to revoke the consent at any time.

Client acknowledges they are consenting to receiving:

- General adoption information
- Information relating to the agency including annual picnic invite and fundraising, or
- Surveys regarding client(s) experience from the agency directly to the e-mail address and/or text message number provided by the client.

_____ (Client's Initials) I consent to the above in order to receive communication from the agency to my e-mail address and/or to my cell phone number provided. I understand that this request to receive e-mails and/or text messages will apply to future communication unless I request a change in writing (revocation form can be requested from agency).

The **cell phone number** that I authorize to receive **text messages** at is: _____

The **e-mail address** that I authorize to receive **e-mail** at is: _____

OR

_____ (Client Initials) I **decline** to receive communication via text.

_____ (Client Initials) I **decline** to receive communication via email.

Please note, Adoption Choices of Colorado does not charge for this service, but standard messaging rates may apply as provided in your wireless plan.

I/We understand and acknowledge that our application fee of \$550.00, which is non-refundable, guarantees our being on Adoption Choices' waiting couples list for a period of one year (if home study approved). We further understand that adoption costs vary from situation to situation, and that upon our being matched with a birth mother and/or child we will be responsible for paying the full estimated amount of that particular situation. We understand that those funds will be placed in an escrow account and costs incurred by the agency on behalf of our birth mother will be paid from that account. We further understand that if the adoption fails, the agency placement fee, minus a \$3,500.00 Agency Services fee, will can be credited to another birth mother/child situation. All other fees and costs, including birth mother pregnancy-related expenses, are at risk.

I/We understand that Adoption Choices of Colorado has a legal obligation to protect any child placed for adoption and to ensure that an adoptive family is able to serve the best interest of the child. I/We understand that my/our records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my/our written consent unless otherwise provided for in the regulations. I/We also understand that I/we may revoke this consent at any time except to the extent that action has been taken in reliance on it.

I/We authorize Adoption Choices of Colorado to both receive and share any information given the agency for the purposes of my/our adoption including requesting criminal history and child abuse and neglect clearances from all states and foreign countries where I/we have lived for the past 5 years.

*****Disclaimer*****

Adoption Choices reserves the right to refuse and or deny an application

Perjury Statement: Any applicant who knowingly or willfully makes a false statement of any material fact or thing in the application is guilty of perjury in the second degree as defined in Section 18-8-503, C.R.S., and, upon conviction thereof, shall be punished accordingly.

SIGNATURES:

First Applicant

Date

Second Applicant

Date

Reviewed & Approved By: _____

Date: _____

