

ADOPTION CONSULTANTS
HOMESTUDY APPLICATION

ADOPTIVE APPLICANT I

ADOPTIVE APPLICANT II

Name (first, middle, last)

Name (first, middle, last)

Place of birth

Place of birth

DOB

SSN

DOB

SSN

Work phone

Cell phone

Work phone

Cell phone

Home Phone

E-mail:

E-mail:

Address: _____

City

County

State

Zip

Directions to your home:

EDUCATION:

EDUCATION:

Last grade completed:

Schools/Degree:

Last grade completed:

Schools/Degree:

EMPLOYMENT:

EMPLOYMENT:

Position:

Years employed:

Gross income last year:

of employers in the past 5 yrs:

Position:

Years employed:

Gross income last year:

of employers in the past 5 yrs:

CRIMINAL HISTORY:

Note all contacts with law enforcement, whether or not they resulted in an arrest or conviction:

IF MARRIED:

Date: _____ Place: _____

Have you ever been separated? _____ If you have been please explain the situation: _____

Have you ever participated in therapy or counseling concerning your marriage? If so when? _____
Please explain: _____

PREVIOUS MARRIAGES: Husband's # of previous marriages: _____
Wife's # of previous marriages: _____

RELIGIOUS AFFILIATION: _____

NATIONALITY/RACE: _____

REFERENCES: (Must include two persons other than relatives who know you well. The third personal reference may be a family member. Your personal references and your employer(s) will be asked to complete a questionnaire and may be contacted by telephone.

Physician: (Parent I)	Organization: Name:	Address: Phone:
Physician: (Parent II)	Organization: Name:	Address: Phone:
Physician: (Children)	Organization: Name:	Address: Phone:
Employer: (Parent I)	Company: Supervisor:	Address: Phone:
Employer: (Parent II)	Company: Supervisor:	Address: Phone:
Personal Reference:	Name:	Address: Phone:
Personal Reference:	Name:	Address: Phone:
Personal Reference:	Name:	Address: Phone:

Monthly gross income: _____
Assets & Savings: _____ Liabilities: _____

Life Insurance Carrier: _____ Amount: _____
Life Insurance Carrier: _____ Amount: _____

Health Insurance Carrier: _____
Health Insurance Carrier: _____

HEALTH/MENTAL HEALTH/CHEMICAL DEPENDENCY:

	APPLICANT #1	APPLICANT # 2
Are you being treated for a chronic condition?	Yes ___ No ___	Yes ___ No ___
Have you been diagnosed with cancer?	Yes ___ No ___	Yes ___ No ___
Have you consulted a mental health professional?	Yes ___ No ___	Yes ___ No ___
Have you experienced problems with drugs or alcohol?	Yes ___ No ___	Yes ___ No ___

If you have answered yes to any of these questions please explain the situation in detail:

WHAT ARE YOUR PLANS FOR ADOPTIVE PLACEMENT?

We plan to adopt internationally: ___yes ___no
We plan to adopt domestically: ___yes ___no
We plan to adopt domestically using an attorney: ___yes ___no

We have identified our referral agency/attorney:
Referral Attorney/Agency: _____ Address: _____
City, State, Zip Code _____ Contact person: _____
Phone: _____ Fax: _____ E-mail: _____

Adoption Consultants is not responsible for information and/or services provided by foreign governments, attorneys, adoption agencies, medical staff, orphanages, adoption facilitators, Citizenship and Immigration Services and/or other United States government entities.

The Homestudy Application and other required documents are necessary for completion of the homestudy. Failure to complete and submit required documents may result in discontinuation of the homestudy process.

By signing this document I/we are agreeing that all information provided in this document and any other written documents as well as all information shared verbally for the purpose of the completion of the homestudy will be accurate with no emission of information. Withholding or giving false information will terminate the services with Adoption Consultants and can result in an approved homestudy being revoked.

Applicant # 1: _____ **Date:** _____
Applicant # 2: _____ **Date:** _____