# **ADOPTIVE HOME APPLICATION**

**FAMILY LIFE SERVICES**

P.O. BOX 4199

LYNCHBURG VA 24502

***(Please type. Handwritten forms will not be accepted.)***

Purpose of Application: Please select as many as apply.

\_\_\_\_ Domestic Infant Adoption Program \_\_\_\_ Domestic Home Study

\_\_\_\_ Post Placement Services \_\_\_\_ Private or Parental Placement Home Study

\_\_\_\_ Other Please Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **Family**

Husband’s Full Name:

Date of Birth: Cell Telephone:

E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Wife’s Full Name:

Date of Birth: Cell Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address:

Home Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax Number:

Other Family Members in the Home:

Name of Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:

Special Health Needs:

*\*\*Use a separate sheet of paper if more than one child is in the home or for any children not living in the home and provide the same information if there are any non-family members living in the home.*

## **Marriage**

Date of Marriage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State:

Is this your first marriage?

 Husband: \_\_\_\_\_ Yes \_\_\_\_\_ No Wife: \_\_\_\_\_ Yes: \_\_\_\_\_ No

*\*\* If no, please attach a copy of Divorce Decree(s) and explain the circumstances on a separate sheet of paper.*

Has there been any infidelity in your marriage?

 Husband: \_\_\_\_\_Yes \_\_\_\_\_No Wife: \_\_\_\_\_Yes \_\_\_\_\_No

*\*\*If yes, please attach a separate statement explaining the incident(s) that occurred and the resolution of this issue.*

## **Health**

Husband’s Health Condition:

Physical or Psychological Diagnosis (past or present):

If yes, please explain:

Have you ever received treatment for?

\_\_\_\_\_ Alcoholism\*\* Date of Treatment:

 Drug Addiction\*\* Date of Treatment:

\_\_\_\_\_ Psychiatric Difficulties\*\* Date of Treatment:

*\*\* If you have a history of alcoholism, previous drug addiction, or psychiatric* *difficulties, please describe in detail on a separate sheet of paper.*

Describe your current use of alcohol or tobacco products:

Wife’s Health Condition:

Physical or Psychological Diagnosis (past or present):

If yes, please explain:

Have you ever received treatment for?

\_\_\_\_\_ Alcoholism\*\* Date of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Drug Addiction\*\* Date of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Psychiatric Difficulties \*\* Date of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_

*\*\* If you have a history of alcoholism, previous drug addiction, or psychiatric difficulties, please describe in detail on a separate sheet of paper.*

Describe your current use of alcohol or tobacco products:

Husband and Wife:

Have you experienced infertility? \_\_\_\_\_ Yes \_\_\_\_\_ No If “No”, skip to next section.

What is your infertility diagnosis?

For what duration of time have you tried to conceive?

What medical steps have you taken to resolve your infertility?

Do you plan to continue infertility treatments?

##  **Education**

Husband:

Circle last year completed:

High School 9 10 11 12 College 1 2 3 4 Graduate 1 2 3 4 Postgraduate 1 2 3 4

Name of College:

Degree Earned: Year Earned:

Graduate School:

Degree Earned: Year Earned:

Post Graduate School:

Degree Earned: Year Earned:

Other Degrees/Certifications:

Wife:

Circle last year completed:

High School 9 10 11 12 College 1 2 3 4 Graduate 1 2 3 4 Postgraduate 1 2 3 4

Name of College:

Degree Earned: Year Earned:

Graduate School:

Degree Earned: Year Earned:

Post Graduate School:

Degree Earned: Year Earned:

Other Degrees/Certifications:

1. **Employment**

Husband’s Present Employment:

Name of Company:

Address:

Dates of Employment: From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To

Position Held: Annual Salary:

Responsibilities:

Business Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours Worked:

Wife’s Present Employment:

Name of Company:

Address:

Dates of Employment: From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To

Position Held: Annual Salary:

Responsibilities:

Business Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours Worked:

1. **Finances**

**ASSETS LIABILITIES**

Real Estate Mortgage

Personal Property Car Loan

Savings Credit Card Debt

Retirement Student Loans

Other Investments Other Liabilities

Total Assets: Total Liabilities:

Have either of you ever filed for bankruptcy? \_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

Do you have homeowner’s insurance? \_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

Name of Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount of Coverage:

Do you have life insurance? \_\_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

Name of Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Amount of Coverage:

Will your health insurance cover an adopted child? \_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_ No

Name of Company:

 **7. Religion** (This section is optional for home study applicants.)

Do you consider yourselves to be Christians?

Husband: Yes No Undecided

Wife: Yes No Undecided

Church:

Address: Telephone:

Pastor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you each been a member?

How regularly do you attend?

Please describe any responsibilities or volunteer positions, within the church:

Husband:

Wife:

1. **Adoption**

How did you hear about our program?

How long have you considered adoption?

Why do you wish to adopt?

Have you ever filled out an application to another adoption agency? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please indicate the other adoption agencies with which you have been or are currently involved. (This will, in no way, affect your ability to work with our agency). Include a statement of what has been completed by each agency, including completed home studies.

We would be open to the consideration of the adoption of a child from the following racial or mixed racial backgrounds:

 Caucasian Asian

\_\_\_\_\_ African American \_\_\_\_\_ Hispanic

\_\_\_\_\_ Hispanic/Caucasian \_\_\_\_\_ Asian/Caucasian

\_\_\_\_\_ African American/Caucasian \_\_\_\_\_ Other

Would you consider adopting a child with a physical or developmental disability?

 \_\_\_\_\_ Yes \_\_\_\_\_ No

What are your fears about adoption?

1. **Recreational Interests**

List family activities:

List personal interests (hobbies, crafts, sports, etc.):

Husband:

Wife:

1. **General Information**

Do you have a criminal record?

Husband: \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please specify, including dates:

Wife: \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please specify, including dates:

Have you ever been arrested even if it did not result in a conviction?

Husband: \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please specify, including dates:

Wife: \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please specify, including dates:

Do you have any traffic violations?

Husband: \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please specify, including dates:

Wife: \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please specify, including dates:

**Please submit the $150.00 non-refundable application fee with your application. This fee is payable by check, cash, or credit card.**

**If you wish to pay be credit card, please check here\_\_\_\_ and we will send you an electronic invoice.**

**Please include a recent picture of your family with your application.**

**The application and picture may be submitted by:**

**Mail: Family Life Services, PO Box 4199, Lynchburg, VA 24502**

**Fax: 434-845-3486**

*For families applying to the Family Life Services Infant Domestic Adoption Program: Family Life Services is committed to making a choice regarding this application within thirty days of the receipt of this application. During the review, the agency may request additional information. The approval decision is contingent upon the ruling of the Executive Committee of the Board of Directors. Our signatures indicate our understanding of this procedure.*

*For families applying for home study or post placement services, a caseworker will contact you as soon as possible (no longer than two weeks from the date of receipt).*

The information contained in this application is a true, complete, and accurate representation of our family. We understand that failure to disclose background information may result in our application being denied.

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

Signature (Husband) Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature (Wife) Date

**\* Please include a separate Getting to Know You form for both husband and wife, as well as a detailed budget form, with the submission of your full application. \***

**\* Family Life Services will keep this application on file for a period of 18 months. If the applicants have not initiated services within 18 months from the date of the application, it will be destroyed, and a new application and application fee will need to be submitted to create a new file at the agency. \***

 Revised September 2022