APPLICATION FOR COLOMBIA ADOPTION

Family Last Name: _____

(If different or hyphenated last name, list both: Wife/Husband)

- ♥ Please print clearly, initial & sign in ink
- ♥ Use additional paper if necessary
- ♥ Please do not leave any fields blank
- ♥ Use N/A or None as applicable

The information you provide in this application is very important in determining your qualifications as an adoptive family. All information provided will remain confidential and will be used only by CCAI personnel and your social worker to assist you in the adoption process. This application will not go to Colombia. Please do not omit items (i.e. number of divorces, arrest records, medical information and therapeutic issues). Failure to provide accurate and complete information may prevent CCAI from processing your application and may result in the closure of your file. CCAI reserves the right to perform its own confidential investigation pertaining to the information provided by you should CCAI deem it necessary.

CCAI ♥ 6920 S. Holly Circle ♥ Centennial, CO 80112-1018 ♥ USA

♥ Phone: 303-850-9998 ♥ Fax: 303-850-9997 ♥ Email: colombia@ccaifamily.org ♥ Website: www.ccaifamily.org ♥

CCAI is a division of Chinese Children Charities

GENERAL INFORMATION

(Please do not leave any blanks)

	WIFE/SELF	HUSBAND/SELF
FULL LEGAL NAME	_____	_____
NAME YOU GO BY	_____	_____
SOCIAL SECURITY NUMBER	_____	_____
BIRTHPLACE (City/State/Country)	_____	_____
DATE OF BIRTH/AGE	DOB_____AGE_____	DOB_____AGE_____
COUNTRY OF CITIZENSHIP*	_____	_____
ETHNICITY	_____	_____
EDUCATION	_____	_____
OCCUPATION	_____	_____
PRIMARY EMPLOYER	_____	_____
HOBBIES/TALENTS	_____	_____
RELIGION	_____	_____

*Non-US citizens must submit a copy of their valid green card and current passport. Naturalized citizens must submit a copy of their Certificate of Citizenship or Certificate of Naturalization.

HOME ADDRESS: _____ _____ _____ _____ _____
STREET ADDRESS CITY COUNTY STATE ZIP CODE

MAILING ADDRESS: _____

(_____)_____ _____ _____
PRIMARY PHONE WIFE E-MAIL HUSBAND E-MAIL (Please star PRIMARY Email)

(_____)_____ (_____)_____ (_____)_____ (_____)_____
WIFE CELL WIFE WORK HUSBAND CELL HUSBAND WORK

Do we have your permission to contact you at work? Wife: **Yes / No** Husband: **Yes / No**

Applicants' Initials_____ _____

DATE OF CURRENT MARRIAGE: _____ **CITY/STATE/COUNTRY**: _____

If current date of marriage is less than 3 years, # of years lived together prior to marriage_____ **WIFE'S MAIDEN NAME: _____**

HAVE EITHER OF YOU BEEN PREVIOUSLY MARRIED? Wife: **Yes / No** Husband: **Yes / No**
If previously married, please list how the marriage ended (i.e. annulment, divorce, death), date and previous spouse's name(s).

	How Ended	Date	Previous Spouse's Name
Wife/Self			
Husband/Self			

CHILDREN: Please list all children – born to or adopted by applicants. (If you do not have any children, please put "N/A")

Name	Age	Gender	Date of Birth	Birth/Adopted*	Ethnicity	Current Location/Custody

*Please note group number for families who have previously adopted through CCAI.

OTHERS IN HOUSEHOLD (incl. anyone living in home, living on property, <u>OR</u> working in the home on a regular basis) Yes _____ No _____

Name	Gender	Date of Birth / Age	Relationship
		/_____	
		/_____	

ARREST HISTORY

HAVE YOU ***EVER*** BEEN ARRESTED FOR ***ANY*** REASON AT ***ANY*** AGE? (Even if it was expunged, dismissed, dropped, charged in another state or as a minor.) Please be aware that failure to disclose ANY arrest history, even if acquitted, not convicted, or not fingerprinted, will result in immediate closure of your adoption file.

WIFE/SELF: YES / NO DATE: _____ REASON: _____ OUTCOME: _____ ☐ **Clearance Attached**

HUSBAND/SELF: YES / NO DATE: _____ REASON: _____ OUTCOME: _____ ☐ **Clearance Attached**

If ***YES,*** please include the following with your application: 1) a detailed explanation of the arrest, written by you and 2) (if available) a copy of the disposition report obtained from the court in the jurisdiction **in which your arrest occurred**.

Applicants' Initials_____ _____

HEALTH INFORMATION

	Height	Weight	Eye Color	Hair Color
Wife/Self	_____	_____	_____	_____
Husband/Self	_____	_____	_____	_____

HAVE YOU EVER HAD (W=Wife, H=Husband)**:**

	NO	YES	DATE/EXPLAIN
Tuberculosis	____	_____	_____
Heart Disease	_____	_____	_____
Sexual Disease	_____	_____	_____
Mental Illness	_____	_____	_____
Lupus	_____	_____	_____
Procedures (1)	_____	_____	_____
Operations (1)	_____	_____	_____
Illness/ Injury Requiring Hospitalization	_____	_____	_____

	NO	YES	DATE/EXPLAIN
Cancer/Tumor	____	_____	_____
Liver Disease	____	_____	_____
Kidney Disease	____	_____	_____
Nervous Disorder	_____	_____	_____
Seizure Disorder/Epilepsy	_____	_____	_____
Genetic Disease	_____	_____	_____
Counseling or Therapy	_____	_____	_____
Alcohol Abuse	_____	_____	_____
Drug Use/Experimentation	_____	_____	_____
Any Physical Impairment (e.g. blindness, deafness, paralysis, missing limbs, etc)	_____	_____	_____

	NO	YES	DATE/EXPLAIN
❖ Have you ever been a victim of child or sexual abuse, or domestic violence?	_____	_____	_____
❖ Have you ever tested positive for HIV and/or Hepatitis B?	_____	_____	_____
❖ Are you currently taking any medications? (1)	_____	_____	_____

If "YES" is checked in any category above, please attach a copy of your doctor's letter to this application. A separate letter is required for each applicant. Each letter should state in layman's terms: a simple description of the medical issue, onset, treatment, outcome (recovered, "controlled with medication," etc.) and recommendation for adoption (e.g., "This person is in good physical and mental condition necessary to provide responsible care for an adopted child"). Your current MD or DO can complete each letter. It does not need to be completed by the physician who treated the medical issue. Please see the footnotes below.

(1) We **do not need** a doctor's letter for the following operations, medical issues, or their related medications: tonsillectomy, appendectomy, minor joint surgery, laser eye surgery, dental surgery, fertility-related issues, C-section, hyper/hypo-thyroidism, cholecystectomy, high cholesterol, cosmetic surgeries and allergies.

Is infertility one of your reasons for pursuing adoption? Yes/No **Are you pregnant or could be pregnant? Yes/No**

HEALTH INSURANCE

HEALTH INSURANCE PROVIDER: _____

Will they cover an adopted child? _____ Will they cover a child with a pre-existing condition? _____

CCAI recommends that adoptive families research their health insurance terms/limits to avoid delays in coverage. We also encourage you to begin thinking about guardianship for your adopted Colombian child. All families will be asked to provide this information during the adoption process.

Applicants' Initials_____ _____

EXTENDED FAMILY – Use additional paper if necessary. Please list all immediate family members (living or deceased).

If we are unable to reach you (e.g., on match day or for post adoption) do we have permission to contact members of your extended family? Please indicate "Yes" or "No" below.

WIFE/SELF

	Name	Age	City/State	Occupation	Phone Number	Y/N
Father:	_____	_____	_____	_____	(_____) _____	_____
Mother:	_____	_____	_____	_____	(_____) _____	_____
Sibling:	_____	_____	_____	_____	(_____) _____	_____
Sibling:	_____	_____	_____	_____	(_____) _____	_____

HUSBAND/SELF

	Name	Age	City/State	Occupation	Phone Number	Y/N
Father:	_____	_____	_____	_____	(_____) _____	_____
Mother:	_____	_____	_____	_____	(_____) _____	_____
Sibling:	_____	_____	_____	_____	(_____) _____	_____
Sibling:	_____	_____	_____	_____	(_____) _____	_____

EMPLOYER : CCAI will **NOT** contact your employer; however, we still need complete information in this application.

	WIFE/SELF	HUSBAND/SELF
Company Name	_____	_____
Supervisor	_____	_____
Street Address	_____	_____
City/State/ZIP	_____	_____
Phone	_____	_____

REFERENCES (Please print clearly)

Please list three personal references (must be non-family members)

	Name	E-mail Address	Mailing Address	Phone Number
1.	_____	_____	_____	(____)_____
2.	_____	_____	_____	(____)_____
3.	_____	_____	_____	(____)_____

Applicants' Initials_____ _____

FINANCIAL INFORMATION

	Name of Employer	Employment Dates	Verifiable Gross Annual Income
WIFE/SELF (Present):	_____	_____	_____
If less than 3 years (Previous):	_____	_____	_____
HUSBAND/SELF (Present):	_____	_____	_____
If less than 3 years (Previous):	_____	_____	_____

OTHER CURRENT ANNUAL INCOME (Source):_____ _____
(Rental / Employment / Interest / Other income)

TOTAL ANNUAL INCOME _____

PRIMARY RESIDENCE ___ Rented ___ Owned Date of Purchase _____ Monthly payment or rent $_____ # of Bedrooms _____

ASSETS		**LIABILITIES**	Owed	Monthly Payment
Primary Residence (appraised value):	$_____	Mortgage Balance:	$_____	$_____
Real Estate (other than primary residence):	$_____	Credit Cards:		
Vehicles: _____	$_____	_____	$_____	$_____
_____	$_____	_____	$_____	$_____
Savings Account(s):	$_____	_____	$_____	$_____
Checking Account(s) (usual balance):	$_____	Bank Loans:		
Bonds: _____	$_____	_____	$_____	$_____
Stocks: _____	$_____	_____	$_____	$_____
Contents of home based on insurance replacement value: (Obtained from home/renters insurance policy)	$_____	Other:		
		_____	$_____	$_____
401K/Retirement: _____	$_____	_____	$_____	$_____
Other*:_____ (*IRA, PERA, etc)	$_____	_____	$_____	$_____
TOTAL ASSETS:	**$_____**	**TOTAL LIABILITIES:**	**$_____**	

NET WORTH: **$_____**

What significant changes do you anticipate in your financial situation, if any? _____

Have you ever filed for bankruptcy? **NO / YES** (if yes, please list date(s)) _____

Please share with us how you are going to finance this adoption.
_____
_____
_____

Applicants' Initials_____ _____

ADOPTION

WHY DO YOU WISH TO ADOPT A CHILD FROM COLOMBIA? _____
_____
_____

Why have you chosen CCAI for this adoption? _____

CHILD or CHILDREN PREFERRED:

☐ Female ☐ Male ☐ Either

I/We are interested in adopting:
☐ One child
☐ More than one child (a sibling group of up to _____ children)

I/We are open to the following medical conditions (if known): _____

Age Range **At the Time of Referral**: _____ to _____ years

FAMILY ASSESSMENT

YES	NO	
☐	☐	Are you presently pursuing adoption possibilities through another agency? Agency name: _____
☐	☐	Have you ever had a home study completed? Date: _____ Agency name: _____
☐	☐	Have you ever been denied for the placement of a child?
☐	☐	Do you currently (or plan to) use any form of corporal/physical punishment (including spanking) on your biological or adopted child(ren)?
☐	☐	Have you ever been denied for the placement of a child?
☐	☐	Have you ever disrupted/dissolved or relinquished a child?
☐	☐	Has a child ever been removed from your home?
☐	☐	Have you ever been investigated for and/or charged with child abuse, sexual abuse or domestic violence?

If you answered **"YES"** to any of the above, please provide a detailed explanation. **Letter Attached?** _____

ADOPTION(S) Through Another Agency

YES	NO	
☐	☐	Have you ever completed an adoption through another agency? Agency name: _____
☐	☐	Have you ever applied and had your application denied for any adoption program? Agency name: _____
☐	☐	Have you ever refused a child referral?
☐	☐	Do you currently have a complete dossier in Colombia through another agency? Agency name: _____

If you answered **"YES"** to any of the above, please provide a detailed explanation. ☐ Letter Attached

Please share with us some details about your previous adoption(s), if any:
Date of adoption finalization: _____ Age of child at time of referral: _____ Health status: _____ Domestic _____: Name of Country _____
Date of adoption finalization: _____ Age of child at time of referral: _____ Health status: _____ Domestic _____: Name of Country _____

Applicants' Initials_____ _____

Your home study will be completed by a CCAI social worker who will be assigned to your family.

IMPORTANT ADOPTION INFORMATION

There are certain risks involved in international adoption. While CCAI will provide you with all available information about the prospective adoptive child and assist you with the entire adoption process, some unpredictable problems and/or events which are beyond CCAI's control may nevertheless occur. These unpredictable problems and/or events include, but are not limited to: adoption requirements or policies promulgated by the Colombian or United States governments, and/or changes in international relations between Colombia and the United States.

In addition, a child may be placed with you with physical and/or emotional problems, minor or major, that have remained partially or totally undiagnosed and which were previously unknown to CCAI.

SIGNATURES

We attest that the information we have provided in this application is true, complete and accurate to the best of our knowledge, and we understand that any and all responses are subject to verification. We have read and understand the information regarding CCAI and the risks involved in international adoption. We understand that the approval of our application does not guarantee the placement of a child. We understand that CCAI reserves the right to close our file at any time if we fail to disclose requested information fully and accurately.

We understand that by signing this application we agree to notify CCAI immediately upon any changes in our personal or family situation including job change, change of address, separation, arrest, divorce, pregnancy, placement of foster or adopted child(ren), significant changes in physical or mental health status, significant changes in financial status or any other significant event at any time during the adoption process. We understand that CCAI reserves the right to close our file should any of these changes disqualify us for a Colombian adoption.

Any applicant who knowingly and 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.

Wife: _____ Date: _____ :
Signature

Husband: _____ Date: _____
Signature

Return with a non-refundable $250 application fee ($150 for families who have previously adopted through CCAI).
Make checks payable to CCAI **or** complete and return the ACH authorization form.

Return by mail/email/fax to: CCAI Colombia Adoption Program
6920 S. Holly Circle
Centennial, CO 80112
colombia@ccaifamily.org
fax) 844.421.9959

FOR CCAI OFFICE USE ONLY

APPLICATION RECEIVED: _____/_____/_____ **FEE RECEIVED: _____/_____/_____ $_____**

REFERENCES SENT: _____/_____/_____ **NUMBER: _____**

□ Non U.S. Citizen? **Green Card Expiration Date: _____**
□ Naturalized Citizen? **A # : _____**

CCAI NOTES:

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APPROVAL DATE: _____/_____/_____ **CASE #: _____**

Medical Conditions Checklist--COLOMBIA

Welcome! CCAI is delighted that you are interested in the Colombia Adoption Program. The Medical Conditions Checklist will help us understand your family's openness in terms of a child's age, gender, and special need(s) and will allow us to consider your family as we receive information on Waiting Children from ICBF in Colombia. Please work together with your spouse to complete the Checklist. If available, your social worker or family doctor can serve as a wonderful resource to help you.

Applicant #1:_____
Applicant #2:_____
Phone: _____
Alt Phone: _____
Email: _____

Desired gender: ○ Female ○ Male ○ No Preference
Age: _____ to _____ years
Siblings: ○ 2 children ○ 3 children ○ 4 children
Age Range of Siblings: _____ to _____ years
Would you consider a child with multiple conditions: ____

Please share with us which special needs your family is open to by circling the conditions you would consider.

FACIAL
Facial malformation (Including hemifacial microsomia)

HEART
Congenital heart disease – minor (ex. VSD, ASD, PFO, PDA, etc.)
Congenital heart disease – major (ex. TOF, multiple or structural pathologies)

BLOOD
Hepatitis B
Hepatitis B Carrier
Thalassemia

VISION/HEARING
Eye – treatable issues
Vision loss - moderate and/or significant/blind
Ear malformation/Ear atresia
Hearing loss - moderate and/or significant/deaf

FAMILY/CHILD HISTORY
Child's mother abused alcohol and/or drugs during pregnancy
History of mental illness in family
History of cognitive delay in family
Fetal alcohol syndrome
History of sexual abuse
History of physical abuse
History of trauma
Brain injury (cranio-cerebral trauma)
Chronic malnutrition
Unknown history of family

BIRTH CONDITIONS
Failure to thrive
Prematurity
Low Birth Weight

DEVELOPMENTAL/BEHAVIORAL
Cognitive delays
Growth delays
Motor delays
Speech delays
ADD/ADHD
Autism spectrum disorders
Maladaptive, aggressive behaviors
Psychiatric disorders (such as schizophrenia/bipolar)
Behavioral disorders - requiring specialized therapy

DIGESTIVE
Anal atresia (imperforate anus)
Gastroschisis
Other digestive disorders

SKIN
Albinism AND low vision
Hemangioma/Lymphangioma
Scar/Burns (moderate to significant/facial)
Vitiligo
Nevus

SKELETAL
Arthrogryposis/Joint disorders
Club foot/feet
Missing/malformed fingers/toes
Missing/malformed hands/arms or feet/legs
One affected limb only and/or Multiple affected limbs
Scoliosis
Short stature/Dwarfism)
Spina bifida (meningocele/myelomeningocele)

NERVOUS SYSTEM
Cerebral anoxia/Brain damage or malformation
Cerebral palsy
Down syndrome
Hydrocephalus
Microcephalus
Meningitis
Neurofibromatosis

GENITAL/URINARY
Ambiguous genitalia
Male genital malformations
Vaginal atresia
Incontinence
Kidney disease/malfunction

OTHER
Epilepsy/Seizure disorder
Paralysis
Teratoma
Cancer
History of Leukemia
HIV
PKU

HEALTHY CHILD
Healthy older child (over 6 years)

Please indicate any other conditions, not listed here, that you may consider:
_____
_____

CCAI ACH Authorization Form

Print Name(s) _____

US Mailing Address _____

City _____State _____Zip Code_____

Phone Number(s) _____

By the signature below I/we authorize CCAI to immediately charge our account for the applicable fees indicated below.

_____ 1st time CCAI Family Application Fee of $250

_____ Returning CCAI Family Application Fee of $150

Account Holder Signature: _____Date: _____
Printing in lieu of signature will be considered authorization to process the above fees.)

Account Holder Name: _____

Account Number: _____

Bank Routing Number: _____

Bank Name: _____

***** Copy of Voided Check or Deposit slip Mandatory *****