

RAINBOW OF LOVE ADOPTION AGENCY, INC.
PARENTING APPLICATION

Adoption

Adoption and Foster Care

Foster Care

Please paste 1 or 2 photos of your family and the front of your house

Directions to the home: _____

Demographics

Man's Name: _____
Last Middle First Title

Woman's Name: _____
Last Middle First Maiden/Title

Residence Address: _____

_____ *City State Zip Code County*

Mailing Address: _____

Phone: _____
Home Business (Husband) Business (Wife) e-mail

Length of time at residence: _____ years and _____ months

If you and your spouse haven't resided in the above address for ten (10) years or more, please provide your previous residence within the last ten (10) years.

Previous Address: _____

City State Zip Code County

Length of time at residence: ____ years and ____ months

Previous Address: _____

City State Zip Code County

Length of time at residence: ____ years and ____ months

Previous Address: _____

City State Zip Code County

Length of time at residence: ____ years and ____ months

PERSONAL INFORMATION

Husband/Male Applicant		Wife/Female Applicant
	Birth date/Age	
	Height/Weight	
	Eye/Hair Color	
	Ethnic Background	
	Indian Tribe <i>(if applicable)</i>	
	Military Experience	
	Occupation	
	Social Security Number	
	Citizenship/Legal Alien Status	
	Birth Place	

Why do you wish to adopt and/or foster at this time? _____

Have you ever had a home study conducted before? _____

Have you ever adopted and/or fostered before? If so, when, where and for whom? _____

List all disabilities, serious illnesses, operations, and chronic conditions you have experienced during the past 10 years. Also list all medications you are taking now _____

List all psychological and/or psychiatric treatment and medication _____

List all convictions and/or deferred adjudication for a crime other than a minor traffic ticket, to include crimes against the person, crimes against the family, and/or public indecency to a child?
Explain: _____

Have either of you ever been involved with a case with the Texas Department of Family and Protective Services involving child abuse? If yes, please explain _____

MARITAL INFORMATION

Are you currently legally married? _____

Date and place of marriage. _____

Have you ever separated? If so, when _____

Have you been previously married? _____

Husband/Male Applicant		Wife/Female Applicant
	Name of Former Spouse	
	Date and Length of Marriage	
	Date and reason for divorce	

CHILDREN IN HOUSEHOLD

Name	Date of Birth	Sex	Race	Biological/Adoptive <i>(If adopted, date of adoption)</i>

CHILDREN LIVING OUTSIDE OF YOUR HOME (ALL AGES)

Name	Date of Birth	Biological/Adopted	Address/Phone #

Are there any others living in your household, either full or part time, that have not been listed? Yes No

If so, please give their name, how long they have been living there, and how long you expect them to remain.

Name	How Long	Will Remain Until

Additional Information Needed

Name of Pet and Species	Vaccination Date

Wife/Female Applicant Sibling Information

Do you have any siblings? ___Yes ___No

If yes, please complete the information below:

Sibling Name	Age	Marital Status	Profession	City/ State of Residence

Husband/Male Applicant Sibling Information

Do you have any siblings? ___Yes ___No

If yes, please complete the information below:

Sibling Name	Age	Marital Status	Profession	City/ State of Residence

EDUCATION

Husband/Male Applicant		Wife/Female Applicant
	Number of formal years of school	
	Certificates/Diplomas/ Degrees/Licensures	
	Major and/or Minor	
	High school, College and or Graduate School	
	Dates of Graduation	

Describe your neighborhood: _____

What are the schools in your area?

Elementary: _____

Jr. High: _____ High: _____

What is the nearest hospital? _____

Is there a pediatrician in the neighborhood that you are considering using for your adopted or foster child?

Will the child have his or her own bedroom? Yes No _____

Do you have reliable transportation? Yes No

REFERENCES

Please list the names, addresses and telephones numbers of five references. Three non-relatives and two relatives.

1. _____
Name *Address* *Phone Number*

2. _____
Name *Address* *Phone Number*

3. _____
Name *Address* *Phone Number*

4. _____
Name *Address* *Phone Number*

5. _____
Name *Address* *Phone Number*

ADDITIONAL INFORMATION AND CHILD CARE

Have you ever been treated for infertility?

Yes No (If yes, please explain-include date(s) of treatment)

Do you speak any foreign languages? Which? _____

What childcare arrangements do you currently have in place? _____

What childcare arrangements will you make for the child/children placed in your home? _____

Who would you use for emergency child care/babysitting? _____

TYPE OF CHILD PREFERRED *

Number of Children _____ Will you accept siblings or twins? _____

Age range: (check all that apply) 0-1 1-6 6-13 13-18

Sex: Female Male Both

Races/Ethnicities (check all that apply)

- Anglo/European American Black/African American Anglo/Black
- Hispanic Hispanic/Anglo Hispanic/Black
- Asian Asian/Anglo Asian/ Black
- Native American Native American/Anglo Native American/Black

**foster parents must be open to all racial and ethnic groups.*

Which of the following special needs can you work with? (Using your families abilities and strengths)

- Adopted previously Hearing Impaired Self Abuser
- Acting out behavior HIV Positive/Aids Self Esteem Low
- ADD/ADHD Infant Alcohol Addition Sexual Acting Out
- Alcohol Abuse Infant Drug Addition
- Animal Cruelty History Learning Disabled Severe Behavioral Problems
- Assault behavior Limited English Proficiency STD
- Developmentally delayed Medically Fragile Sibling Group
- Down Syndrome Moderate Behavioral Problems Speech Disabled
- Drug Abuse Mental Retardation Teen Parent
- Emotionally Disturbed Military Dependat Terminal Illness

- | | | |
|--|--|--|
| <input type="checkbox"/> Enuresis/Encopresis | <input type="checkbox"/> Mobility Impaired | <input type="checkbox"/> Visually Impaired - minor |
| <input type="checkbox"/> Failure to Thrive | <input type="checkbox"/> Phobias | <input type="checkbox"/> Visually Impaired - major |
| <input type="checkbox"/> Fire setting history | <input type="checkbox"/> Physically Disabled | <input type="checkbox"/> Other Behavioral problems |
| <input type="checkbox"/> Gang Activity/Affiliation | <input type="checkbox"/> Physically abusive | <input type="checkbox"/> Other Emotional Problems |
| <input type="checkbox"/> Health Disabled | <input type="checkbox"/> Pregnant teenager | <input type="checkbox"/> Other Medical Problems |
| <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Runaway | <input type="checkbox"/> None |

ADDITIONAL INFORMATION

6. Please list two (2) persons who will always know how to get in touch with you in case of an emergency.

Name *Address* *Phone Number*

Name *Address* *Phone Number*

IMPORTANT (Please read the following carefully before signing this document)

The information given on this application is true and complete to the best of my/our knowledge and belief and I/we understand that any misrepresentation of information will be cause for rejection of this application and will terminate my/our relationship with Rainbow of Love Adoption Agency, Inc.

Rainbow of Love Adoptions Agency, Inc. maintains confidentiality of all information given. At no times will your file be released to any other agency beyond our own without prior written permission within the limits of Texas law. Representatives of the Texas Department of Family and Protective Services will review this document during scheduled program and contract reviews/audits.

Signature of Husband/Male Applicant

Signature of Wife/Female Applicant

Date Signed

Date Signed