

# Adoption Journeys of Arizona, Inc.

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## Adoption Application

FATHER

MOTHER

Applicant Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work phone:

\_\_\_\_\_

Length of Residency in your state: \_\_\_\_\_

E-mail \_\_\_\_\_ E-mail: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Age: \_\_\_\_\_

Citizenship

\_\_\_\_\_

Birthplace

\_\_\_\_\_

Race \_\_\_\_\_

\_\_\_\_\_

Highest Education Level \_\_\_\_\_

\_\_\_\_\_

Graduate/Degree \_\_\_\_\_

\_\_\_\_\_

Occupation \_\_\_\_\_

\_\_\_\_\_

Religion \_\_\_\_\_

\_\_\_\_\_

Employed by: \_\_\_\_\_

\_\_\_\_\_

Employer Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Employer Phone \_\_\_\_\_

\_\_\_\_\_

Length Employed \_\_\_\_\_

\_\_\_\_\_

How long in current position \_\_\_\_\_

\_\_\_\_\_

If less than two years, what was your previous position? \_\_\_\_\_

Annual Income \$ \_\_\_\_\_ \$ \_\_\_\_\_

Social Security # \_\_\_\_\_

Passport Issue Date \_\_\_\_\_

Date Passport Expires \_\_\_\_\_

(If passport is in maiden name, must apply for an amendment)

**EMERGENCY CONTACT:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ I hereby give permission to Adoption Journeys of Arizona, Inc. to contact this person in case of emergency. Please initial here

**PROSPECTIVE FATHER**

If previously married, please give dates of marriage and divorce or other termination.

Marriage Date	Spouse Name	Date Terminated	How Terminated

**PROSPECTIVE MOTHER**

If previously married, please give dates of marriage and divorce or other termination.

Marriage Date	Spouse Name	Date Terminated	How Terminated

**HOUSEHOLD MEMBER INFORMATION**

Please include all adult members of your household.

Name	Relationship	Date of Birth	Social Security Number

Each household member will need to relate their medical and psychological history; this history may be self-declared during the home visit.

**FAMILY CONTACT INFORMATION**

Please include the names, relationship, address and phone numbers for your immediate family members and emancipated adult children.

Name	Relationship	Address	Phone Number

Have you experienced a bankruptcy? Please explain \_\_\_\_\_

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**LEGAL PROCEEDINGS**

Have applicant(s) been a party to any of the following?

Event	Yes	No	Year
A. Dependency actions			
B. Severance or termination of parental rights actions			
C. Child support enforcement actions			
D. Actions involving allegations of child maltreatment			
E. Adoption proceedings			
F. Criminal proceedings other than minor traffic violations			

If yes to any above items, describe below, identifying dates, circumstances and persons involved.

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Any additional information you would like to share regarding answers to earlier questions? You may attach a separate sheet, if necessary.

**PAST HISTORY:**

Have either of you ever experienced or been treated for chemical or alcohol dependency? Y / N

If Yes, please explain. Include dates of treatment:

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Have either of you ever sought treatment from a mental health professional, a counselor, psychologist or psychiatrist?

Dates and Duration:

Please explain:

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**PROSPECTIVE FATHER:**

**Personal Health**

Information on Physician who will be completing your medical exam

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Medical Background**

Have you been treated for:	YES	NO
Chronic illness (please name)		
Psychiatric disorders (please name)		
Cancer		
Heart disease (please name)		
Diabetes (if yes, how is it treated)		
Infertility		
Are you within a healthy weight range for your height?		
Do you have any restrictions on activities?		
Do you have any disabilities or special travel needs?		

Your physician will need to provide a letter; a format will be provided.

Do you **currently** have any of the diagnoses listed below?

Yes    No

Cancer \_\_\_\_\_ Type:

Tuberculosis \_\_\_\_\_ Date:

Bone and/or Muscle Disease \_\_\_\_\_ Type:

Neurological Disease \_\_\_\_\_ Type:

Sexually Transmitted Disease \_\_\_\_\_ Diagnosis:

Psychiatric conditions where parent is disabled \_\_\_\_\_ Diagnosis:

Are you currently being treated by a Physician? **Father:** \_\_\_\_\_ Yes    No

Any other conditions for which you are receiving treatment \_\_\_\_\_ Yes    No

Please describe all hospitalizations within the last five years:

List all current medications prescribed: (Dosage, frequency) List on separate sheet if necessary, and attach to form.

**HEALTH INSURANCE:**

Name of Insurer: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_

**PROSPECTIVE MOTHER:**

**Personal Health**

Information on Physician who will be completing your medical exam

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Medical Background**

	YES	NO
Have you been treated for		
Chronic illness (please name)		
Psychiatric disorders (please name)		
Cancer		
Heart disease (please name)		
Diabetes (if yes, how is it treated)		
Infertility		
Are you within a healthy weight range for your height?		
Do you have any restrictions on activities?		
Do you have any disabilities or special travel needs?		

Your physician will need to provide a letter; a format will be provided.

Do you **currently** have any of the diagnoses listed below?

Cancer	_____	_____	<u>Yes</u>	<u>No</u>
_____	_____	_____	Type:	
Tuberculosis	_____	_____	Date:	
_____	_____	_____	Type:	
Bone and/or Muscle Disease	_____	_____	Type:	
_____	_____	_____	Type:	
Neurological Disease	_____	_____	Type:	
_____	_____	_____	Type:	
Sexually Transmitted Disease	_____	_____	Diagnosis:	
_____	_____	_____	Diagnosis:	
Psychiatric conditions where parent is disabled	_____	_____	Diagnosis:	
_____	_____	_____	Diagnosis:	

Are you currently being treated by a Physician? **Mother:** \_\_\_\_\_ Y \_\_\_\_\_ N \_\_\_\_\_

Any other conditions for which you are receiving treatment \_\_\_\_\_ Y \_\_\_\_\_ N \_\_\_\_\_

Please describe all hospitalizations within the last five years:

List all current medications prescribed: (Dosage, frequency) List on separate sheet if necessary, and attach to form.

**HEALTH INSURANCE:**

Name of Insurer: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Effective Date: \_\_\_\_\_

**LIFE INSURANCE**

**Prospective Father**

Type: \_\_\_\_\_  
Amount: \$ \_\_\_\_\_  
Beneficiary: \_\_\_\_\_

**Prospective Mother**

\_\_\_\_\_

**MARRIAGE INFORMATION:**

Date of Marriage: \_\_\_\_\_ Place \_\_\_\_\_

Children in the Home:

Name	DOB	Sex	Adopted?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Others living in household:

Name	DOB	Sex	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Adult Children: (18 and over)

Name:	DOB	Sex	Address/Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Can we contact you at your place of business? Father: Yes: \_\_\_\_\_ No \_\_\_\_\_  
 Mother: Yes: \_\_\_\_\_ No \_\_\_\_\_

Best Time to call Father: \_\_\_\_\_ Mother: \_\_\_\_\_

In the **past**, have you ever worked with another adoption agency? \_\_\_\_\_ Yes \_\_\_\_\_  
 \_\_\_\_\_ No \_\_\_\_\_

If Yes, please provide the following information on the agency:

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Dates of Service: \_\_\_\_\_  
 Services used: \_\_\_\_\_  
 Outcome: \_\_\_\_\_

Have either of you ever had an unfavorable home study? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

Does applicant have a prior history of adoption certification (home study), including prior applications for certification? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, identify agency providing services:

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Has the applicant ever been denied certification or been refused a recommendation for adoption by an agency or court? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, give date(s) and name of agency involved.

Date	Agency or court issuing denial or refusing to recommend applicant
_____	_____
_____	_____

Have either of you been turned down for placement of a child by an adoption agency or attorney? Y N  
 If yes, please explain

\_\_\_\_\_

Have either of you ever had a child removed from your home, whether biological, foster, or adopted? Y N  
 If yes, for what reasons?

\_\_\_\_\_

Have either of you ever been reported for child abuse? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

Have either of you ever been past due on any court-ordered child support? \_\_\_\_\_ Y \_\_\_\_\_ N \_\_\_\_\_  
 Monthly Payment: \$ \_\_\_\_\_

Have either of you been involved in domestic violence?  
 \_\_\_\_\_

**Have you ever been arrested or convicted of a crime other than a minor traffic offense?**

*If you have reason to believe that an infraction will be noted on your Police or FBI Clearance, you will be required to provide 1) a document from the court or a legal authority attesting to the disposition of the case and 2) an addendum to your Home Study referencing the event. Answering **Yes** to this question does not automatically disqualify you for our program.* \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain:  
 \_\_\_\_\_

**ADOPTION PLANS:**

Have you previously adopted? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
 If Yes, please explain:

\_\_\_\_\_

