

# APPLICATION FOR TAIWAN 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 Taiwan. 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.

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*CCAI is a division of Chinese Children Charities*

# GENERAL INFORMATION

(Please do not leave any blanks)

WIFE

HUSBAND

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**

**DATE OF CURRENT MARRIAGE:** \_\_\_\_\_ **CITY/STATE/COUNTRY:** \_\_\_\_\_

If current date of marriage is less than 5 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	_____	_____	_____
Husband	_____	_____	_____

**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, OR 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: YES / NO DATE: \_\_\_\_\_ REASON: \_\_\_\_\_ OUTCOME: \_\_\_\_\_  Clearance Attached

HUSBAND: 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**.

## HEALTH INFORMATION

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

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

	NO	YES	DATE/EXPLAIN		NO	YES	DATE/EXPLAIN
Tuberculosis	_____	_____	_____	Cancer/Tumor	_____	_____	_____
Heart Disease	_____	_____	_____	Liver Disease	_____	_____	_____
Sexual Disease	_____	_____	_____	Kidney Disease	_____	_____	_____
Mental Illness	_____	_____	_____	Nervous Disorder	_____	_____	_____
Lupus	_____	_____	_____	Seizure Disorder/Epilepsy	_____	_____	_____
Procedures (1)	_____	_____	_____	Genetic Disease	_____	_____	_____
Operations (1)	_____	_____	_____	Counseling or Therapy	_____	_____	_____
Illness/ Injury Requiring Hospitalization	_____	_____	_____	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) and (2)	_____	_____	_____

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 Taiwanese child. All families will be asked to provide this information during the adoption process.

**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**

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

**HUSBAND**

	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**

**HUSBAND**

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.	_____	_____	_____	(____) _____



## ADOPTION

WHY DO YOU WISH TO ADOPT A CHILD FROM TAIWAN? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 Taiwan 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 \_\_\_\_\_







## Medical Conditions Checklist--TAIWAN

Welcome! CCAI is delighted that you are interested in the Taiwan 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 Cathwel Services in Taiwan. 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.

### Adoptive Family Name(s):

Husband: \_\_\_\_\_

Wife: \_\_\_\_\_

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

Alt Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Desired gender:  Female  Male  No Preference

Desired age (at time of match): \_\_\_\_\_ to \_\_\_\_\_ years

Please share with us which special needs your family is open to.

**Checking YES** does not commit you to a particular child, but a YES indicates a strong level of education and comfort with a particular special need. Before submitting your Checklist, you should have discussed any conditions marked YES with a medical specialist as well as your insurance company.

**Checking MAYBE** indicates that you have researched a particular condition and would be prepared to review the file of a child with this condition.

### Yes No Maybe

#### FACIAL

- Cleft lip AND palate (Children with cleft lip only are NOT typically available) May be unilateral or bilateral, first to third degree
- Facial malformation (Including hemifacial microsomia)

#### HEART

- Congenital heart disease – minor (typically includes VSD, ASD, PFO, PDA, etc)
- Congenital heart disease – major (typically includes TOF, multiple or structural pathologies)

#### BLOOD

- Hepatitis B
- Thalassemia

#### SKELETAL

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

#### VISION/HEARING

- Ear malformation (microtia/atresia, may be unilateral/bilateral)
- Hearing loss (partial/moderate)
- Hearing loss (significant/deaf)
- Eye - nystagmus/strabismus/ptosis
- Eye - cataracts/glaucoma
- Vision loss (in one eye, partial/moderate)
- Vision loss (significant/blind)

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

### Yes No Maybe

#### SKIN

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

#### NERVOUS SYSTEM/DEVELOPMENTAL

- Cerebral anoxia/Brain damage or malformation
- Cerebral palsy
- Down Syndrome
- Hydrocephalus
- Delayed development (may be physical and/or mental, beyond typical expected institutional delays)
- ADD/ADHD

#### GENITAL

- Ambiguous genitalia
- Male genital malformations (including hypospadias/micropenis/undescended testicles/etc)

#### DIGESTIVE

- Anal atresia (imperforate anus)
- Gastroschisis

#### OTHER

- Epilepsy/Seizure disorder
- Paralysis
- Teratoma

#### HEALTHY CHILD

- Healthy older child (over 6 years)

Please indicate if your family will consider a child with multiple conditions:

Yes  No



**CCAI Credit Card Authorization Form**

Print Name(s) \_\_\_\_\_

Address \_\_\_\_\_

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

Phone Number(s) \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_ Application Fee of \$ **250.00** \_\_\_\_\_ (First time CCAI families)

\_\_\_\_\_ Application Fee of \$ **150.00** \_\_\_\_\_ (Returning CCAI families)

An additional two percent (2.5%) will be automatically calculated and charged to cover credit card company's fees.

By printing my name below I/we authorize CCAI to immediately charge my credit card for the Application Fee (and applicable credit card company fees) indicated above.

MasterCard

Visa

Account Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CSV Code: \_\_\_\_\_  
(from back of the card)

Cardholder's Name: \_\_\_\_\_  
(Please print exactly as it appears on credit card)