

# 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](mailto:colombia@ccaifamily.org) ♥ Website: [www.ccaifamily.org](http://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**

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, 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/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.

## HEALTH INFORMATION

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

### 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)	_____	_____	_____

**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.

**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.	_____	_____	_____	(____) _____



## 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 \_\_\_\_\_

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](mailto:colombia@ccaifamily.org)  
**fax) 844.421.9959**





## 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.

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### 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.

\_\_\_\_\_ 1<sup>st</sup> 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.)

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Account Holder Name: \_\_\_\_\_

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

Bank Routing Number: \_\_\_\_\_

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

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