

APPLICATION FOR COLOMBIA ADOPTION

Family Last Name: _____
(If different or hyphenated last name, list both: Applicant 1/Applicant 2)

- ♥ 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 ♥

GENERAL INFORMATION

(Please do not leave any blanks)

APPLICANT 1/SELF

APPLICANT 2/SELF

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

DOB _____ AGE _____

*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 APPLICANT 1 E-MAIL APPLICANT 2 E-MAIL (Please star

PRIMARY Email)

() _____ () _____ () _____ () _____
APPLICANT 1 CELL APPLICANT 1 WORK APPLICANT 2 CELL APPLICANT 2 WORK

Do we have your permission to contact you at work? Applicant 1: **Yes / No** Applicant 2: **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 _____ APPLICANT 1'S MAIDEN NAME:

HAVE EITHER OF YOU BEEN PREVIOUSLY MARRIED? Applicant 1: **Yes / No** Applicant 2: **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
Applicant 1/Self			
Applicant 2/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.

APPLICANT 1/SELF: YES / NO DATE: _____ REASON: _____ OUTCOME: _____ ☐ Clearance Attached

APPLICANT 2/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
Applicant 1/Self	_____	_____	_____	_____
Applicant 2/Self	_____	_____	_____	_____

HAVE YOU EVER HAD (Applicant 1, Applicant 2):

	NO	YES	WHO/DATE/EXPLAIN		NO	YES	WHO/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	_____	_____	_____	Alcohol Abuse	_____	_____	_____
Drug Use/Experimentation _____	_____	_____	_____	Any Physical Impairment	_____	_____	_____
(Colombia prohibits the use of Marijuana/illegal drugs)				(blindness, deafness, paralysis, missing limbs, etc)			

	NO	YES	WHO/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.

APPLICANT 1/SELF

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

APPLICANT 2/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.

APPLICANT 1

Company Name	_____
Supervisor	_____
Street Address	_____
City/State/ZIP	_____
Phone	_____

APPLICANT 2

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.	_____	_____	_____	(____) _____

FINANCIAL INFORMATION**Name of
Employer****Employment
Dates****Verifiable Gross
Annual Income**

APPLICANT 1/SELF (Present): _____

If less than 3 years (Previous): _____

APPLICANT 2/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**

Primary Residence (appraised value): \$ _____

Real Estate (other than primary residence): \$ _____

Vehicles: _____ \$ _____

_____ \$ _____

Savings Account(s): \$ _____

Checking Account(s) (usual balance): \$ _____

Bonds: _____ \$ _____

Stocks: _____ \$ _____

Contents of home based on insurance
replacement value: \$ _____

(Obtained from home/renters insurance policy)

401K/Retirement: _____ \$ _____

Other*: _____ \$ _____

(*IRA, PERA, etc)

TOTAL ASSETS: \$ _____**LIABILITIES**

Mortgage Balance: Owed \$ _____ Monthly Payment \$ _____

Credit Cards: _____ \$ _____

_____ \$ _____

_____ \$ _____

Bank Loans: _____ \$ _____

_____ \$ _____

_____ \$ _____

Other: _____ \$ _____

_____ \$ _____

_____ \$ _____

_____ \$ _____

_____ \$ _____

_____ \$ _____

_____ \$ _____

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.

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.

Applicant 1: _____ Date: _____
Signature

Applicant 2: _____ Date: _____
Signature

Return with a non-refundable \$300 application fee (\$200 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) 303.850.9997

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:

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

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:

Residential History-Other State & Other Country Child Abuse Registries

	<u>Applicant 1:</u>	<u>Applicant 2:</u>
Full Legal Name:		
Previous Names Used:		
Race (Ethnicity):		
DOB:		
SS#		
Driver's License #		
Current Home Address		

	<u>Children in the home aged 14 and over</u>	<u>Children in the home aged 14 and over</u>
Full Legal Name:		
Driver License #		
Race (Ethnicity):		
DOB:		
SS#		

	<u>Other person(s) living OR working in the home (over the age of 18):</u>	<u>Other person(s) living OR working in the home (over the age of 18):</u>
Full Legal Name:		
Previous Names Used:		
Driver License #		
DOB:		
SS#		
Current Home Address		

Please list ALL the States and Countries that you or Other Adults in the home have lived in since the age of 18 years!!

Applicant 1 (use additional form if necessary)

Address (ex. 119 Smith Drive)	City, State, Zip Code OR City, Province/State and Country	Date Range START (Month, Year)	Date Range END (Month, Year)

Applicant 2 (use additional form if necessary)

Address (ex. 119 Smith Drive)	City, State, Zip Code OR City, Province/State and Country	Date Range START (Month, Year)	Date Range END (Month, Year)

Children living in the home over the age of 18 (use additional form if necessary)

Address (ex. 119 Smith Drive)	City, State, Zip Code OR City, Province/State and Country	Date Range START (Month, Year)	Date Range END (Month, Year)

Other person living or working in the home (use additional form if necessary)

Address (ex. 119 Smith Drive)	City, State, Zip Code OR City, Province/State and Country	Date Range START (Month, Year)	Date Range END (Month, Year)

* Please note: Due to the Hague Convention adoption Home Study requirements, we are required to complete child abuse registry checks for all states and/or countries that the applicants and all adult household members lived in since the age of 18. There may be additional search fees assessed for child abuse registry checks requested per state or foreign countries listed on this form.

***Please return to CCAI with your Application for Adoption**



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 \$300

_____ Returning CCAI Family Application Fee of \$200

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 Bank Account Confirmation Required***