

# HOME STUDY ONLY - FORMAL ADOPTION APPLICATION

 **INTERNATIONAL**

Country from which you're adopting: \_\_\_\_\_

Agency through which you're adopting:

Agency name: \_\_\_\_\_

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

Agency phone: \_\_\_\_\_

Caseworker: \_\_\_\_\_

 **DOMESTIC**
 Caucasian

 African-American

 AA/Caucasian

 Other Mixed Race

Application Date: \_\_\_\_\_

**Working with:**

AAI Office in:

- Jenison, MI
- Farmington Hills, MI
- Lansing, MI
- Saginaw, MI
- West Hartford, CT

 Have you ever had a completed home study or home study update?  yes  no

If yes, who completed it? \_\_\_\_\_ Current as of \_\_\_\_\_

 Have you ever been denied an adoptive home study?  yes  no

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

 Are you requesting **ONLY** an adoptive home study and **NOT** an adoptive placement from this agency?

 yes  no

Families interested in an international adoptive home study must complete the International Adoption Awareness education requirements before submitting the formal application. Because the following information will be transferred onto legal documents, it is extremely important that you type or print as clearly and accurately as possible, making sure to complete all the information. Return this form to the agency. Please include payment of applicable fees due with formal application as indicated in the current fee schedule. When a caseworker has been assigned, you will receive a call for your first appointment.

Last name: \_\_\_\_\_ Home Telephone: ( ) \_\_\_\_\_  
 Address: \_\_\_\_\_ Adoptive Father's Cell Phone: ( ) \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Adoptive Mother's Cell Phone: ( ) \_\_\_\_\_  
 County: \_\_\_\_\_  
 Do you live within the city limits? \_\_\_\_\_ Emergency Phone: ( ) \_\_\_\_\_  
 If not, what township? \_\_\_\_\_ Emergency Contact Person: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_

**SOCIAL INFORMATION**
Adoptive Father
Adoptive Mother

Full Legal Name:	_____	_____	_____	_____	_____	_____
	(first)	(middle)	(last)	(first)	(middle)	(last)
Wife's Maiden Name:	_____					
Social Security #:	_____					
Driver's License #:	_____					
Birth Date:	_____					
Birthplace (city & state):	_____					
Height & Weight:	_____					
Eye & Hair Color:	_____					
Education:	_____					
Last School Attended:	_____					
Occupation:	_____					
Military:	_____					
(Branch / Rank / Date):	_____					
Hobbies / Interest:	_____					
Community Activities:	_____					

**MARRIAGE**

Date: \_\_\_\_\_ Location: \_\_\_\_\_ Officiated: \_\_\_\_\_

Previous Marriages: Adoptive Father Adoptive Mother

To whom: \_\_\_\_\_

Dates: \_\_\_\_\_

Location: \_\_\_\_\_

Reason for termination: \_\_\_\_\_

Number and dates of divorces: \_\_\_\_\_

**RELIGION**

Church (name): \_\_\_\_\_

Pastor / Priest / Rabbi: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_ Distance from church: \_\_\_\_\_

\_\_\_\_\_ Church/Minister e-mail address: \_\_\_\_\_

Participation (describe): \_\_\_\_\_

**HEALTH**

Adoptive Father Adoptive Mother

Primary Physician: \_\_\_\_\_

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

\_\_\_\_\_

Telephone #: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

(Reasons): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Psychotherapy / \_\_\_\_\_

Counseling (Reasons): \_\_\_\_\_

\_\_\_\_\_

Any prolonged use of alcohol, drugs, or narcotics? \_\_\_\_\_

Any history of sexual abuse as a child or adult? \_\_\_\_\_

**CRIMINAL HISTORY**

Adoptive Father Adoptive Mother

Arrests/Convictions: \_\_\_\_\_

Date(s): \_\_\_\_\_

Convictions of Child Abuse \_\_\_\_\_

or Neglect: \_\_\_\_\_

NOTE: Please provide a criminal disposition and detailed personal account of arrests or convictions and child abuse or neglect.

**HOME AND COMMUNITY**

List all persons / children living in your home excluding yourselves. Also list any children, regardless of age or residence, from previous marriages. List name, birthdate and place of residence. If your child is adopted please identify from which country and the placing agency. Please attach a separate page for any additional children.

	<u>Child 1</u>	<u>Child 2</u>	<u>Child 3</u>
Name:	_____	_____	_____
Birthdate:	_____	_____	_____
Place of Residence:	_____	_____	_____
Biological or Adopted?:	_____	_____	_____
If adopted, identify agency:	_____	_____	_____
If adopted, identify country:	_____	_____	_____
Occupation/School:	_____	_____	_____
Social Security Number:	_____	_____	_____
Local schools:	_____		Distance from home: _____

**EMPLOYMENT**

	<u>Adoptive Father</u>	<u>Adoptive Mother</u>
Employer:	_____	_____
Work Telephone:	_____	_____
Position:	_____	_____
Date of Hire:	_____	_____
Annual Gross Income:	_____	_____
Benefits:	_____	_____
Name of person to contact for reference: (Supervisor or H.R.):	_____	_____
Address:	_____	_____
	_____	_____

If you are self-employed, please list business associate/partner and include address:

\_\_\_\_\_

What is the adoptive mother's plan for employment once the child is placed?

Full-time employment?   
  Part-time employment?   
  Leave of absence?   
  Home full-time?

What is the adoptive father's plan for employment once the child is placed?

Full-time employment?   
  Part-time employment?   
  Leave of absence?   
  Home full-time?

What is the plan for daycare, if needed? \_\_\_\_\_

Prior employment: (Accounting for ten years to current employment, list the employer, gross income, and length of employment.)

Adoptive Father: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Adoptive Mother: \_\_\_\_\_

\_\_\_\_\_

**FINANCIAL INFORMATION**

Home: Own or rent? \_\_\_\_\_ Lot size: \_\_\_\_\_ Monthly payments: \_\_\_\_\_  
 If owned, present market value: \_\_\_\_\_ Mortgage balance: \_\_\_\_\_  
 Square footage \_\_\_\_\_  
 Automobiles: \_\_\_\_\_ Monthly payments: \_\_\_\_\_  
 Liquid assets: Savings: \_\_\_\_\_ Checking: \_\_\_\_\_  
 Investments: Stocks: \_\_\_\_\_ Bonds: \_\_\_\_\_  
 Other income sources (list with monthly income): \_\_\_\_\_  
 \_\_\_\_\_  
 Other Property: \_\_\_\_\_  
 Other Investments: \_\_\_\_\_

**REFERENCES**

List four (4) references who know you well. Include at least one neighbor (past or present). Do not include your employer or physician. Letters will be sent to each person listed during the processing of this application.

<u>Name</u>	<u>Address</u>	<u>Telephone #</u>	<u>Relationship</u>
1. _____	_____	( ) _____	_____
	_____		
	_____		
2. _____	_____	( ) _____	_____
	_____		
	_____		
3. _____	_____	( ) _____	_____
	_____		
	_____		
4. _____	_____	( ) _____	_____
	_____		
	_____		

NOTE:

- If you have school age children, other reference requests will be given to you by the caseworker for the teacher or administrator of each child.

**LIFE INSURANCE**

<u>Type</u>	<u>Company</u>	<u>Value of Policy</u>	<u>Beneficiary</u>

**HEALTH INSURANCE -** Indicate when an adopted child would become eligible for coverage:

<u>Company</u>	<u>Covered Individuals</u>

**CHECKLIST -** All items below must be sent in with the formal application

- 1. Fees due with formal application as indicated in the current fee schedule.
- 2. A floor plan of your apartment or home. Identify the rooms.
- 3. A copy of your Health Insurance card, both front side and back side. Also indicate when an adopted child would become eligible for coverage on your insurance.
- 4. All home studies/updates completed on your behalf if done by someone other than our agency.
- 5. Photos of yourselves, the front of your home, and any children in the family.
- 6. Placing agency information.
- 7. Statement of Adoption Orientation and Understanding Risks—signed and dated.
- 8. Medical and Lifestyle Checklist—signed and dated.
- 9. Post Placement/Post Adoption Cooperation Agreement—signed, dated, and notarized.
- 10. International Adoption Advisory—signed and dated (International clients only).
- 11. Fee and Refund Policy—signed and dated.
- 12. Consent for Use and Disclosure of Health Information (Mother and Father) and Acknowledgment of Receipt of Notice of Privacy Practices—both signed and dated.
- 13. International Adoption Awareness Education—initialed, signed, and dated.
- 14. Copy all documents before sending them in.

I/We have completed this application honestly and as accurately and completely as possible. I/We understand that this information will be covered in the home study. I/We accept the agency policy that children will only be placed with heterosexual parents and affirm that I/we am in compliance with that policy. I/We also accept the agency policy that children will be placed only with parents who agree not to withhold medical treatment for the child against the advice of medical personnel. I/We also understand that acceptance of this application by the agency begins the adoption process and does not represent a commitment that the agency will place a child with me/us. Throughout the adoption process I/we commit to being open and honest in providing necessary information.

In the event of a disruption/dissolution, the agency will assist the adoptive family in cooperating with all necessary and appropriate agencies, court officials, and other responsible persons to obtain a proper resolution on behalf of the best interest of the child. Fees for these other services may include agency hourly rate plus mileage and actual expenses. A copy of the Disruption/Dissolution Procedure is available upon request.

We hereby authorize this agency or its representatives to pursue any investigation (financial or otherwise) it deems necessary in order to properly evaluate us as an adoptive family. We understand and agree that at times it may require independent investigations conducted by personnel hired by the agency.

We hereby acknowledge that we have read and understand the applicable fees and expenses associated with the program we've chosen.

Finally, I/we agree to first use the grievance procedure of the agency, and then if necessary, cooperate in using mediation and binding arbitration to resolve differences between us and the agency. In the event of such a dispute, we agree first to submit the dispute to facilitative mediation. We agree to use the services of a mediation program mutually acceptable to the agency and to us. We further agree to pay one-half of the fees and expenses of any such mediator. We agree to participate fully in the mediation process in a good faith effort to resolve our differences with the agency.

Nevertheless, in the event the mediation process does not resolve our dispute with the agency, we agree that the sole and exclusive method for resolving the dispute shall be binding arbitration in accordance with this paragraph. The arbitration shall be governed by and conducted in accordance with the arbitration rules of the American Arbitration Association. Unless we and the agency agree otherwise, the arbitration shall be conducted in the city of the agency's corporate office. We agree to pay one-half of the arbitrator's fees and expenses, and understand that the agency will be responsible for paying the other one-half of these fees and expenses. The award of the arbitrator may be enforced by any court of competent jurisdiction. We agree to keep the arbitration, and any information disclosed during the course of the arbitration proceeding, as strictly confidential. However, this confidentiality provision is not intended to apply to, or in any way restrict, a family's right to file a complaint with the Bureau of Children and Adult Licensing of the Michigan Department of Human Services.

Date: \_\_\_\_\_ Adoptive Father (signature): \_\_\_\_\_

Date: \_\_\_\_\_ Adoptive Mother (signature): \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?**

Please fill out the following information completely.

Last Name: \_\_\_\_\_ First Name(s): \_\_\_\_\_

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

How did you hear about this agency? (please check all that apply)

- I am a former client
- From a former client
- From a friend
- Agency web site
- Adoptive Families Magazine
- Other agency: please list \_\_\_\_\_
- Yellow Pages
- Discovery Health Channel "Adoption Stories"
- www.Adoption.com web site
- Other web site: please list \_\_\_\_\_
- Internet search engine: please list \_\_\_\_\_
- Church flyer
- Church bulletin: please list \_\_\_\_\_
- Newspaper advertisement in \_\_\_\_\_ newspaper
- Newspaper article in \_\_\_\_\_ newspaper
- Community calendar in \_\_\_\_\_ newspaper/magazine
- Television: please list \_\_\_\_\_
- Radio: please name station \_\_\_\_\_
- Doctor's office: please list \_\_\_\_\_
- Other: please list \_\_\_\_\_

**GETTING STARTED**

Ready to get connected? Here are a few ways you can get started today!

**E-newsletter**

The agency's quarterly e-newsletter keeps you up-to-date with what's going on in the agency. It includes new programs, new products, and stories from families who have completed the process you're about to begin. Sign up below and we'll get you started, or visit the web site at [www.AdoptionAssociates.net](http://www.AdoptionAssociates.net) to sign up from home.

**Q & A E-Mails**

The agency offers once weekly Q & A e-mails for our international and domestic programs. You can sign up for only the program that you're interested in—if you've already decided—or sign up for them all to observe what's going on at the agency. You can also participate by submitting any questions you'd like to have answered. Sign up below and we'll get you started, or visit the web site at [www.AdoptionAssociates.net](http://www.AdoptionAssociates.net) to sign up from home.

E-mail address: \_\_\_\_\_ State: \_\_\_\_\_  
(print clearly)

Please check all that you'd like to receive:

- Quarterly e-newsletter       Kazakhstan questions       Ukraine questions
- China questions               Nepal questions               Domestic questions
- Ethiopia questions           Russia questions

Note: Once you are signed up, you will receive an e-mail confirmation. In this confirmation, there will be a link to "opt-in" to receive your information. If you wish to stop receiving the e-newsletter or Q & A e-mails, you may do so at any time.

**PLACING AGENCY INFORMATION**

Please provide us with the following information at the time you submit your formal application.

**A. Pertinent Information**

Name of Placing Agency: \_\_\_\_\_

Contact Person: \_\_\_\_\_

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

street number and street

\_\_\_\_\_

city state zip

Phone Number of Placing Agency: (\_\_\_\_) \_\_\_\_\_  
area code

Fax Number of Placing Agency: (\_\_\_\_) \_\_\_\_\_  
area code

We authorize Adoption Associates, Inc. to release our completed adoptive home study and any or all necessary home study documents to our placing agency \_\_\_\_\_ and also give permission for communications between the agencies for the purpose of adoption planning.

\_\_\_\_\_  
Adoptive Father Date

\_\_\_\_\_  
Adoptive Mother Date

**B. Format for Adoptive Home Study**

Dependent on agency requirements and country requirements, this agency is often required to submit adoptive home studies in a format different than our own. Please obtain from your placing agency the home study format they require and **submit a copy of it to us with this application.**

**C. Other Documentation**

Dependent on the country requirements, you may need additional documentation from your caseworker. Please submit copies of additional documentation with your formal application to minimize delays in your case. A few examples of the documents which may be required are agency license, caseworker license, FIA 3005, inter-agency agreement, and dossier documents.

**D. Post Placement/Post Adoption Requirements**

We will be happy to provide post placement/post adoption services if requested. Please check with your placing agency to see what post placement/post adoption services will be required and complete the information below.

Is the adoption finalized in the country? \_\_\_\_\_ (*international clients only*)

How many reports are required?\* \_\_\_\_\_

What is the frequency of each report? \_\_\_\_\_

Must the visits take place:

on the phone? \_\_\_\_\_

in the office? \_\_\_\_\_

in the home?\*\_ \_\_\_\_\_

\*For all Russia placements, we require a minimum of four in-home visits.

Clients will be invoiced for ALL post placement/post adoption services upon our receipt of notification of the post placement/post adoption requirements from the placing agency. These services must be paid in full upon receipt of the invoice. A post placement/post adoption agreement will not be signed until payment is received in full.

Thank you very much for this information. It will surely help to move your home study along more quickly and smoothly.

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**STATEMENT OF ADOPTION ORIENTATION AND UNDERSTANDING OF RISKS**

Accomplishing an adoption through Adoption Associates, Inc. (AAI) requires a commitment on the part of both agency and adoptive client. The agency and each of its workers are committed to making the process the best it can be with the given circumstances of each case. From the first consultation through all the processes of an adoption, to the final decree, the steps of adoption as required by this agency and by the State of Michigan, and the risks involved in adoption, are shared and explained in detail.

We as prospective adoptive parent(s) have received adoption orientation materials which have helped us understand the process set forth at Adoption Associates, Inc. to accomplish an adoption and can be referred to for answers to many questions. Through this orientation we also understand the emotional, financial, and legal risks that may be involved with an adoption and the policy and procedures that the agency has adopted. We have been informed of the particular needs and characteristics of children able to be adopted. We also have been informed of the legal process for adoption. We understand the services and resources Adoption Associates, Inc. provides.

We acknowledge that we have received and read the adoption orientation materials, including the fee schedule, program statement, and grievance procedure, of Adoption Associates, Inc., a private non-profit adoption agency licensed by the State of Michigan. We understand and agree to comply with the policies and procedures set forth at AAI, and accept the risks inherent in the process of adoption, whether it be a domestic or an international adoption.

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Adoptive Father (signature)

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Adoptive Mother (signature)

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Adoptive Father (printed)

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Adoptive Mother (printed)**CASEWORKER STATEMENT:**

I state that the prospective adoptive parent(s) named above did receive the information and orientation required in accordance with the Licensing Rules for Child Placing Agencies established by the State of Michigan Department of Human Services through the Bureau of Children and Adult Licensing. This orientation was in compliance with Rule 604 and/or Rule 707, as applicable, and included a review of all of the following: (caseworker to initial when complete)

- (a) Program statement, policies, and procedures. Rules 604 and 707.
- (b) Services and resources available. Rules 604 and 707.
- (c) Fees and charges for services. Rules 604 and 707.
- (d) Needs and characteristics of children available for adoption. (Rule 707 only: N/A for HSO services)
- (e) Legal process for adoption. (Rule 707 only: N/A for HSO services)

The prospective adoptive parent(s) are requesting a home study completed by AAI. This orientation was provided to the applicants before the adoptive evaluation was conducted.

The prospective adoptive parent(s) are requesting a placement only through AAI. This orientation was provided to the applicants prior to determining their suitability to parent an adopted child.

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Adoption Caseworker, AAI

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Date

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**MEDICAL AND LIFESTYLE CHECKLIST - Adoptive Father**

Each country has rules as to what types of medical conditions or lifestyles they will accept in regard to individuals adopting from their country. In order to assist us in determining if you will be able to adopt from the country of your choice—or to best choose the country that will most likely place a child with you—please check any medical conditions you have been diagnosed with or lifestyle issues that apply to you, either in the past or present, and answer the corresponding questions:

- |  |  |
|--|--|
| <input type="checkbox"/> Alcoholism                      | <input type="checkbox"/> Liver Disease/hepatitis/ jaundice |
| <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Lung Disease, Tuberculosis        |
| <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Mental Illness                    |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Mental Impairment                 |
| <input type="checkbox"/> Blood Transfusion(s)            | <input type="checkbox"/> Mood Disorder                     |
| <input type="checkbox"/> Cancer or Tumor                 | <input type="checkbox"/> Neurological Disorder             |
| <input type="checkbox"/> Depression                      | <input type="checkbox"/> Obesity                           |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Personality Disorder              |
| <input type="checkbox"/> Drug Abuse                      | <input type="checkbox"/> Physical Impairment               |
| <input type="checkbox"/> Epilepsy, Seizures              | <input type="checkbox"/> Sexually Transmitted Disease      |
| <input type="checkbox"/> Head Injuries                   | <input type="checkbox"/> Smoking                           |
| <input type="checkbox"/> Heart Disease                   | <input type="checkbox"/> Stroke                            |
| <input type="checkbox"/> High Blood Pressure/Cholesterol | <input type="checkbox"/> Suicide Attempt                   |
| <input type="checkbox"/> HIV / AIDS                      | <input type="checkbox"/> Thyroid Disease                   |
| <input type="checkbox"/> Homosexuality                   | <input type="checkbox"/> Ulcer In Stomach/ duodenum        |
| <input type="checkbox"/> Kidney Problems                 |  |

Are there any medical conditions not listed above that you have been diagnosed with?

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Please indicate which medications you are currently taking with or without a prescription and the reason(s) you are taking this medication.

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I state that I have been truthful and have provided information on all medical conditions and lifestyle issues that apply to me to the best of my knowledge. I understand that certain medical conditions or lifestyle issues may not be accepted by the program of my choice or by any of our current international programs.

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Adoptive Father (signature)

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Date

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**MEDICAL AND LIFESTYLE CHECKLIST - Adoptive Mother**

Each country has rules as to what types of medical conditions or lifestyles they will accept in regard to individuals adopting from their country. In order to assist us in determining if you will be able to adopt from the country of your choice—or to best choose the country that will most likely place a child with you—please check any medical conditions you have been diagnosed with or lifestyle issues that apply to you, either in the past or present, and answer the corresponding questions:

- |  |  |
|--|--|
| <input type="checkbox"/> Alcoholism                      | <input type="checkbox"/> Liver Disease/hepatitis/ jaundice |
| <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Lung Disease, Tuberculosis        |
| <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Mental Illness                    |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Mental Impairment                 |
| <input type="checkbox"/> Blood Transfusion(s)            | <input type="checkbox"/> Mood Disorder                     |
| <input type="checkbox"/> Cancer or Tumor                 | <input type="checkbox"/> Neurological Disorder             |
| <input type="checkbox"/> Depression                      | <input type="checkbox"/> Obesity                           |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Personality Disorder              |
| <input type="checkbox"/> Drug Abuse                      | <input type="checkbox"/> Physical Impairment               |
| <input type="checkbox"/> Epilepsy, Seizures              | <input type="checkbox"/> Sexually Transmitted Disease      |
| <input type="checkbox"/> Head Injuries                   | <input type="checkbox"/> Smoking                           |
| <input type="checkbox"/> Heart Disease                   | <input type="checkbox"/> Stroke                            |
| <input type="checkbox"/> High Blood Pressure/Cholesterol | <input type="checkbox"/> Suicide Attempt                   |
| <input type="checkbox"/> HIV / AIDS                      | <input type="checkbox"/> Thyroid Disease                   |
| <input type="checkbox"/> Homosexuality                   | <input type="checkbox"/> Ulcer In Stomach/ duodenum        |
| <input type="checkbox"/> Kidney Problems                 |  |

Are there any medical conditions not listed above that you have been diagnosed with?

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Please indicate which medications you are currently taking with or without a prescription and the reason(s) you are taking this medication.

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I state that I have been truthful and have provided information on all medical conditions and lifestyle issues that apply to me to the best of my knowledge. I understand that certain medical conditions or lifestyle issues may not be accepted by the program of my choice or by any of our current international programs.

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Adoptive Mother (signature)

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Date

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**POST PLACEMENT/POST ADOPTION COOPERATION AGREEMENT**

From: \_\_\_\_\_  
Family Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State Zip

In accordance with the post placement/post adoption requirements of the country of origin for my/our child(ren), I/we individually and together state that we understand and accept our responsibility to cooperate with this agency, a non-profit agency, and to provide them with the access and information required to complete post placement/post adoption reports at the specified times as given by the placing agency. This agency will forward the reports to the placing agency.

The adoptive family and the placing agency are solely responsible for submitting pictures and reports to the country. It is the responsibility of the family or placing agency to apostille the reports if necessary.

In the event I/we should relocate our residence prior to the completion of the post placement/post adoption process, I/we agree that I/we will complete the remaining required post placement/post adoption reports with a local licensed agency in my/our state of residence, provide the agency with my/our new address, and if adopting from Russia, inform the Russian Embassy of my/our new address.

\_\_\_\_\_  
Adoptive Father (signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Adoptive Mother (signature)

\_\_\_\_\_  
Date

Signed and sworn to before me in \_\_\_\_\_ County, \_\_\_\_\_  
(State),

on \_\_\_\_\_, 2 \_\_\_\_\_.

Notary Stamp

Notary Signature: \_\_\_\_\_

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**INTERNATIONAL ADOPTION ADVISORY - (International clients only)**

Today, more and more families are considering international adoption. Some have given much thought to their decision to build their family in this way, and have educated themselves on the process and issues involved. Some families have not yet given sufficient time and effort to considering such a decision. The following information is to educate and alert families to the realities of international adoption.

You are considering what many have found to be a most exciting, emotional and ultimately rewarding experience in life. It will surely test your patience, perseverance, and emotional strength. You will need the support of family and friends. Other international adoptive parents can also be very supportive, and we encourage you to seek out this support system should you decide to proceed.

An international adoption can be a long and complicated process. Once you have completed the initial paperwork, you will have very little, if any, control over the process. This can be very frustrating. In international adoption, you are dealing with countries where the culture and way of getting things done are different from how we do things here. Some countries permitting international adoption may have unstable governments or there may be strong anti-international adoption sentiment in the country even though it is legal. There may be delays in your adoptive process or even the halting of it caused by strikes, moratoriums, scandals, long vacation periods or complete changes of governments. Children available for adoption from foreign countries are in the custody of their country of birth. All adoption procedures must be completed under the laws of the child's country of birth. We do not have the authority to mandate activities or direct individuals in the foreign country for the benefit of American families. Although a child may be referred to you, the child is not yours until finalization of the in-country adoption process by decree and visa approval by the U.S. Embassy. Until that time, the child remains in the custody of his/her country of birth and may be withdrawn from adoption regardless of the adoptive family's wishes. We have no control over this.

Your only control over the process will be at the beginning when you complete your home study, submit your immigration work, and prepare the dossier for the foreign government. When these are completed, you are considered ready to accept the referral of a child.

**THE CHILD**

Children in other countries become available for adoption for many reasons. Some are born out of wedlock. Because there is little or no help for single mothers with dependent children in foreign countries, some mothers release their children for adoption in order to provide a better life for the child. Poverty, ill health, death, divorce, abuse, or abandonment can also be reasons for children to enter the child welfare system. Often, very little background information is available. Rarely is there any significant medical, prenatal, social or developmental history for the child or his/her biological family. Sometimes even actual birthdates are unknown. Sometimes the prospective adoptive family will not receive a picture of the child at the time of the referral. Occasionally, pictures are available at a later time during the process. Medical evaluations attempt to identify serious medical problems, but some problems may be undiagnosed. Medical practices abroad often do not allow for the comprehensive screening that is available in the United States. Families who adopt internationally must understand the reality of medical risk.

Children adopted internationally may also have suffered emotional trauma or deprivation caused by institutional life, multiple moves, loss of a loved one, neglect or abuse. Developmental delays are common in these children and it is impossible to determine whether these delays are due to a lack of stimulation and are correctable, or whether the child has a genetic mental deficiency.

Older children from foreign countries have limited educational experiences. It may take them many years to catch up. Children may also have undiagnosed language or learning disabilities.

Families should be familiar with the appearance of people from the country of their choice for adoption. If you have a strong prejudice or ill feelings toward people of a different race, skin color or culture, you should not consider foreign adoption.

To summarize, families who adopt children from overseas must recognize that there are no guarantees as to health, intelligence, psychological stability, appearance, development, or behavior of the child.

I have read and understand the international adoption advisory.

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Adoptive Father (signature) (printed)

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Date

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Adoptive Mother (signature) (printed)

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Date

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**FEE AND REFUND POLICY****DOMESTIC AND INTERNATIONAL**

The agency has made a good faith effort to provide a comprehensive schedule of adoption fees. However, the agency cannot guarantee the final amount of a family's adoption fees and expenses. All fees, including agency, Convention country, and third party fees, are subject to change during the adoption process. Prospective adoptive parent(s) is/are required to pay the fees according to the fee schedule in effect when the fee is invoiced (if invoiced by AAI) or when the fee becomes due (for those fees which are not invoiced by AAI).

The Agency Fee is paid in increments throughout the adoption process. Once the initial increment is paid, the sum of the Agency Fee Payments will not exceed the total Agency Fee in effect for that program at the time of the initial payment.

Fees are charged based on both direct and indirect services provided. All or a portion of a fee may be due prior to completion of a specific service. Any portion of a fee that is not paid prior to completion of a service will be due in full upon completion of that service. If payments are not received as scheduled, adoption services may be suspended until outstanding balances have been paid. Failure to pay outstanding balances for an extended period of time may result in the case being closed.

**INTERNATIONAL ONLY**

The agency does not customarily charge additional fees and expenses beyond those disclosed in the fee schedules. In the event that unforeseen additional fees or charges are incurred in the Convention country, the agency will charge such additional fees and expenses only under the following conditions:

1. Additional fees and expenses will be disclosed to prospective adoptive parent(s) in writing.
2. The agency will obtain consent from prospective adoptive parent(s) prior to expending additional funds in excess of \$1,000.
3. Written receipts will be provided to prospective adoptive parent(s) for any additional fees and expenses paid directly by the agency in the Convention country.

**DOMESTIC AND INTERNATIONAL**

In the event that either the agency or the Convention country is unable to complete your adoption process in the program for which you have applied or if the prospective adoptive parent(s) choose to withdraw from an adoption program, the following refund policy will apply:

1. All fees payable to AAI, except for International Program Fees, are nonrefundable once they are paid.
2. International Program Fees paid to the Convention country are not refundable by the agency. The agency will submit a refund request to the Convention country, however, the agency has no control over whether the funds will be refunded or not. The Convention country will make this determination, and their decision is final.
3. Fees paid directly to third parties in the U.S. or the Convention country are nonrefundable by the agency.

AAI Administration reserves the right to make exceptions to the refund policy in the event that such exceptions would benefit prospective adoptive parent(s). Refunds to which prospective adoptive parent(s) are entitled will be provided within sixty days of the completion of the delivery of services.

We/I, the prospective adoptive parent(s), have read the Fee and Refund Policy and agree to abide by the expectations set forth.

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Adoptive Father (signature)

(printed)

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Date

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Adoptive Mother (signature)

(printed)

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Date

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## INTERNATIONAL SERVICES

This agency is able to provide services to you as outlined below. Please note that if you are working with one of our networking agencies, some of these services may be performed by that agency, rather than directly by this agency.

- **International Adoption Awareness Education:** There is required reading for families considering international adoption. Topics include: the international adoption process, risk education, USCIS requirements, dossier preparation, fee schedules, and physical and emotional health associated with children referred for adoption. Please see fee schedule for applicable charges.
- **For in-state residents:** Home study and post placement/post adoption services are available. Please see fee schedule for applicable charges.
- **For out-of-state residents:** The agency may be able to recommend home study agencies within your state. Please see fee schedule for applicable charges.

If you have requested placement services from the agency through one of our international programs, the following services are included in your program fee. If you have requested only a home study, the following services are available and are billed at the agency hourly rate (see fee schedule).

- **USCIS Assistance:** The agency can assist you with USCIS paperwork throughout the adoption process.
- **Dossier Preparation:** The agency can assist you with country-specific dossier preparation.
- **Education:** The agency can provide private or group consultations with families needing information before or after their adoption on such issues as: health and/or emotional issues, school issues, learning difficulties, attachment and bonding issues, cultural education and awareness, adoption issues, adopting older children, adopting siblings or unrelated children, etc.
- **Adoption Finalization:** The agency can offer guidance to adoptive families in finalizing their adoption in the United States.

In the event of a disruption/dissolution, the agency will assist the adoptive family to cooperate with all necessary and appropriate agencies, court officials, and other responsible persons to obtain a proper resolution on behalf of the best interests of the child. Fees for these other services may include agency hourly rate plus mileage and actual expenses. A copy of the Disruption/Dissolution Procedure is available upon request.

At this agency, you will benefit from and appreciate the wealth of experience of our staff with adoption issues, cultural differences, and dossier and USCIS preparation. Whether you have chosen this agency to complete your home study, placement, or both, you can feel confident that the services you need will be provided.

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**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

**OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 15, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence and qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

#### PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.50 for each page, \$0 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Election Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

#### QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**CONTACT OFFICER:** Kathy Rietberg  
Adoption Associates  
616.667.0677  
1338 Baldwin Street  
Jenison, MI 49428

(Please Retain For Your Records)

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**ADOPTIVE MOTHER - CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our A Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**PRINT NAME**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Names: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

**You are entitled to a copy of this consent after you sign it.  
Include completed Consent in the client's chart.**

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**REVOCAION OF CONSENT**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**ADOPTIVE FATHER - CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our A Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**PRINT NAME**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Names: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

**You are entitled to a copy of this consent after you sign it.  
Include completed Consent in the client's chart.**

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**REVOCAION OF CONSENT**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

Please Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- \_\_\_\_\_ Individual refused to sign
- \_\_\_\_\_ Communications barriers prohibited obtaining the acknowledgement
- \_\_\_\_\_ An emergency situation prevented us from obtaining acknowledgement
- \_\_\_\_\_ Other (Please Specify)

\_\_\_\_\_  
Print Name/Title

\_\_\_\_\_  
Signature/Date

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

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Signature \_\_\_\_\_

Date \_\_\_\_\_

**For Office Use Only**

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- \_\_\_\_\_ Other (Please Specify)

\_\_\_\_\_  
Print Name/Title

\_\_\_\_\_  
Signature/Date