

DOMESTIC FORMAL ADOPTION APPLICATION

Race of child desired:

Caucasian African-American African-American/Caucasian Other Mixed Race

Type of adoption:

Designated Agency matched Unknown

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 AAI? yes no

Working with:

AAI Office in:

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

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 provide an application fee of \$500.00 when submitting this Formal Application. If you would like the agency to do your home study or home study update, please include a \$1,000.00 home study deposit. Upon receipt, we will call you for your first appointment.

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

SOCIAL INFORMATION

Adoptive Father

Adoptive Mother

Full Legal Name:	_____	_____	_____	_____	_____	_____
	(first)	(middle)	(last)	(first)	(middle)	(last)
Wife's Maiden Name:	_____		_____			
Social Security #:	_____		_____			
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 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): _____

Arrest(s) (Explain): _____

Has your driver's license ever been revoked?: Yes _____ No _____

Yes _____ No _____

Do you have any restrictions on your driver's license?: Yes _____ No _____

Yes _____ No _____

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:	_____	_____
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, only if this agency is preparing your home study. If this agency is not doing your home study, the references are not needed. 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>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL INSURANCE FORM

Health insurance carrier: _____

Name of insured: _____

Indicate when your insurance is effective:

_____ Date of custody Other (be specific) _____

_____ Date of placement

When there is more than one health insurance provider, please state which is primary for your child:

Please attach copies of the front and back of your health insurance cards (husband and wife).

In preparation for the placement of a child into your home, the agency would like to assist you by providing the following information:

The agency applies for six months of Medicaid coverage on all Michigan-born children placed through our agency. This is done for the following two reasons:

1. To cover services rendered at time of birth, not covered by other insurance.
2. To cover medical emergencies (and/or catastrophic illnesses) for this child from the date of birth until the date of effective coverage by your health insurance.

The Medicaid ID number is kept on file at the central office of the agency.

Families residing outside of Michigan will receive coverage from date of birth until the child leaves the state. Medicaid **does not** cross state lines.

This Medicaid coverage is **not** intended to replace your personal insurance and should **not** be used inappropriately (e.g. well-baby checks). It is very important that you, as prospective parents, research your personal health insurance policy regarding coverage for a child placed for adoption and be well informed and timely in placing your child on your personal health insurance. It is **your** responsibility to obtain health insurance coverage as soon as possible for your child.

The state Department of Human Services requires the following information from you. Please complete this form and mail promptly to your agency. Please retain a copy for your personal records.

CHECKLIST -Must be sent in with the formal application

- 1. \$500.00 application fee and \$1,000.00 home study deposit, if applicable.
- 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 at what time an adopted child would become eligible for coverage on your insurance.
- 4. A copy of your driver's license. (One per applicant.)
- 5. All home studies/updates completed on your behalf if done by someone other than this agency.
- 6. Consent For Use and Disclosure of Health Information (Mother And Father), and Acknowledgement of Receipt of Notice of Privacy Practices—both signed and dated.
- 7. Copy all documents before sending to the agency.

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): _____

AFFIDAVIT OF MEDICAL CARE

We, _____, as prospective adoptive parents, affirm that we understand and agree with the agency policy regarding medical care for a child placed in our care. That policy is described below;

“This agency will place children only into homes with parents who agree to seek medical attention when necessary for the child. In addition, parents must agree not to withhold medical treatment for the child against the advice of medical personnel.”

We understand that the full intent of this policy is to provide children with the medical care that they need in times of emergency, and this care might include the use of blood and any other related plasma products.

By signing this affidavit we, understanding the policy and in the best interests of the child, pledge to provide any medical treatment for a child as recommended by a licensed medical physician.

Adoptive Father (signature)

Date

Adoptive Mother (signature)

Date

Witness (signature)

Date

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 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 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.

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)

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.**

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: _____

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.**

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: _____

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

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 _____

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- _____ Communications barriers prohibited obtaining the acknowledgement
- _____ An emergency situation prevented us from obtaining acknowledgement
- _____ Other (Please Specify)

Print Name/Title

Signature/Date

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.

 Adoptive Father (signature) (printed) Date

 Adoptive Mother (signature) (printed) Date