Children's Home Society of Minnesota

Lutheran Social Service of Minnesota

APPLICATION PART 1

Identified Child Adoption

Children's Home and LSS (CH/LSS) have over 275 years of combined experience in foster care and adoption. Our caring staff is here to guide you through your journey.

Our services are available to all people regardless of race, color, ethnicity, religion, disability, national origin, sex, sexual orientation, gender identity or gender expression.

Submitting Application Part 1 is free. Information gathered on this form will help us assist you in determining your program options and eligibility. Each program has its own unique set of eligibility requirements. Please visit our website (chlss.org) for more details.

PLEASE INCLUDE THE FOLLOWING ITEMS ALONG WITH YOUR APPLICATION:

1. One photo of family members who live in your home
2. One photo of the outside of your home
3. Supporting documents (if applicable)

PLEASE SEND COMPLETED APPLICATION PART 1 TO:

Children's Home & LSS, c/o Deb Harder
1605 Eustis Street
Saint Paul, MN 55108
welcome@chlss.org | (fax) 651.646.0436

We will contact you within five business days following the receipt of your Application Part 1 to continue the application process. If you have any questions prior to completion of this form, please contact us (800.952.9302; welcome@chlss.org).

PROSPECTIVE PARENT(S)

	APPLICANT 1	APPLICANT 2
Legal Name (Last, First)		
Preferred Name		
Preferred Pronouns		
Street Address		
County, City, State, Zip Code		
Preferred Phone Number		
Email Address		
Date of Birth		
Place of Birth (City, State, Country)		
Country of Citizenship		
Race		
LGBTQ (Yes or No)		
Gender		
Religion		
Marital Status		
If Married, Place & Date		
Job Title & Employer		
Annual Salary		
Highest Level of Education		

FAMILY

Household Income _____

Net Worth (assets minus debts) _____

History of Bankruptcy ☐ Yes ☐ No

Date(s) of Bankruptcy (if applicable) _____

Will health insurance provide coverage for child upon placement? ☐ Yes ☐ No

Health Insurance Provider _____

CHILDREN ALREADY IN THE HOME (if applicable)

CHILD NAME	BIRTH DATE	SEX	RACE	RELATIONSHIP
1. _____	_____	☐ M ☐ F	_____	☐ Adopted ☐ Birth
Current Living Arrangement _____				☐ Foster
2. _____	_____	☐ M ☐ F	_____	☐ Adopted ☐ Birth
Current Living Arrangement _____				☐ Foster
3. _____	_____	☐ M ☐ F	_____	☐ Adopted ☐ Birth
Current Living Arrangement _____				☐ Foster
4. _____	_____	☐ M ☐ F	_____	☐ Adopted ☐ Birth
Current Living Arrangement _____				☐ Foster
5. _____	_____	☐ M ☐ F	_____	☐ Adopted ☐ Birth
Current Living Arrangement _____				☐ Foster

If you have more than five children, please include additional information in an attached document.

OTHERS LIVING IN HOME

NAME	BIRTH DATE	SEX	RELATIONSHIP
1. _____	_____	☐ M ☐ F	_____
2. _____	_____	☐ M ☐ F	_____

If you have additional individuals in your home, please include information in an attached document.

PREVIOUS MARRIAGES

	APPLICANT 1	APPLICANT 2
1. Date of Divorce/Death	_____	_____
Reason for Ending	_____	_____
2. Date of Divorce/Death	_____	_____
Reason for Ending	_____	_____
3. Date of Divorce/Death	_____	_____
Reason for Ending	_____	_____

If you have more than three marriages that have ended in death or divorce, please include information in an attached document.

CHILD WELFARE HISTORY

Have you ever had a child removed from your home? ☐ Yes ☐ No ☐ Yes ☐ No

If yes, please attach explanation.

MEDICAL

	APPLICANT 1	APPLICANT 2
Height		
Weight		
Body Mass Index (BMI)		
Have you ever been hospitalized?	☐ Yes ☐ No *If yes, please attach dates and reason for hospitalization.*	☐ Yes ☐ No
Do you currently have, or have a history of, disease and/or chronic conditions?	☐ Yes ☐ No *If yes, please attach the following: date of diagnosis, prognosis, and impact on ability to parent. (Note: a doctor's letter may be required. If available, please attach. If not, one may be requested.)*	☐ Yes ☐ No
Have you undergone infertility testing or treatment?	☐ Yes ☐ No *If yes, please explain.* _____	☐ Yes ☐ No
Have you ever received counseling or therapy of any kind?	☐ Yes ☐ No *If yes, please attach dates of duration and reason for therapy.*	☐ Yes ☐ No
Have you ever been treated for any mental health conditions (such as depression, anxiety, etc.)?	☐ Yes ☐ No *If yes, please attach the following: date of service, diagnosis and prognosis. (Note: a doctor/therapist's letter may be required.)*	☐ Yes ☐ No
Please list any prescription medication you've taken in the past two years, including start/end dates and condition treated.	_____ _____ _____ *If you have additional medications to list, please include in an attached document.*	_____ _____ _____

Please include additional medical information, even that which you may consider minor, in an attached document.

BACKGROUND HISTORY AFFIDAVIT

Please verify whether or not you have a history (as a victim or offender) of:

	APPLICANT 1	APPLICANT 2
Child Protection Matters	☐ Yes ☐ No	☐ Yes ☐ No
Juvenile Criminal Offenses	☐ Yes ☐ No	☐ Yes ☐ No
Sexual Abuse	☐ Yes ☐ No	☐ Yes ☐ No
Child Abuse	☐ Yes ☐ No	☐ Yes ☐ No
Abuse Against Vulnerable Adults	☐ Yes ☐ No	☐ Yes ☐ No
Domestic Violence	☐ Yes ☐ No	☐ Yes ☐ No
Assault or Other Violence	☐ Yes ☐ No	☐ Yes ☐ No
Arrest and/or Criminal Convictions	☐ Yes ☐ No	☐ Yes ☐ No
Substance Abuse and/or Alcohol/Chemical Dependency	☐ Yes ☐ No	☐ Yes ☐ No

If you have answered yes to any of the above as an offender, please attach the following: a detailed explanation of the incident(s) (date, location, charges, etc.), police report, fines and/or disciplinary action required (include: terms of sentence and/or probation, dates of incarceration).

ADOPTION

If you've previously adopted, please provide the name of the agency through which you adopted and the placement date(s). _____

_____

Have you ever had a home study or placement of a child denied/dissolved/disrupted? ☐ Yes ☐ No

Do you have a current or prior home study? ☐ Yes ☐ No

Do you plan to move during the adoption process? ☐ Yes ☐ No

Have you applied to another agency for adoption or foster care? ☐ Yes ☐ No

Have you ever withdrawn from a home study process? ☐ Yes ☐ No

IDENTIFIED CHILD INFORMATION

NAME OF CHILD	CHILD'S BIRTHDATE	PLACE CHILD IS LIVING (INCLUDE CITY, STATE, COUNTRY)	IS CHILD ATTENDING SCHOOL?

Does the child have any health issues? ☐ Yes ☐ No If yes, please briefly describe.

Are you related to the child? ☐ Yes ☐ No If yes, describe how you are related.

Please fill in the following information, if known.

Is the child's mother alive? ☐ Yes ☐ No Is the child's father alive? ☐ Yes ☐ No

Are/were the child's parents married? ☐ Yes ☐ No

If child's parents are living where do they live? Mother_____ Father_____

Name and contact information of child's guardian/caregiver_____

Are there other siblings who will remain in country? ☐ Yes ☐ No

Have you taken any steps to adopt the child or been granted legal guardianship of the child? If so, what are they? (Please list on a separate sheet if necessary)

Do you have or can you get relinquishment documents or prove that the child is an orphan? ☐ Yes ☐ No

Can you get a copy of the child's birth certificate? ☐ Yes ☐ No

Does the child have a passport? ☐ Yes ☐ No

Home study agency (if other than CH/LSS) - Complete if you are working with a local agency that will provide home study services.

Agency name_____ Contact person_____ Phone number_____

Email address of contact person_____ Agency address_____

AUTHENTICATION

I hereby verify that I have answered truthfully to the above questions. Misrepresentation may affect our ability to provide adoption services.

APPLICANT 1 | Signature _____ Printed Name _____ Date _____

APPLICANT 2 | Signature _____ Printed Name _____ Date _____

*You are not a client of CH/LSS until a service contract is complete.