APPLICATION PART 1

Children's Home Society of Minnesota

Lutheran Social Service of Minnesota

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

There is no fee associated with the Application Part 1. The information you provide will help us determine your program options and eligibility. Eligibility requirements may vary by program. Please visit chlss.org for more details.

PLEASE INCLUDE THE FOLLOWING ITEMS WITH THIS FORM:

1. One photo that includes all members of your household
2. One photo of the outside of your home/building
3. Supporting documents (if applicable)

PLEASE SEND COMPLETED FORM TO:

Email: welcome@chlss.org Fax: 651.646.0436

Mail: CH/LSS
Attn: Adoption Information Team
1605 Eustis St.
Saint Paul, MN 55108
(*Email preferred*)

We will confirm receipt of your Application Part 1. Our review process can take up to 5 business days to complete. If you have any questions, please contact our team at welcome@chlss.org or 651.646.7771

PROSPECTIVE PARENT(S)

	APPLICANT 1	APPLICANT 2
Legal Name (last, first)		
Preferred Name		
Pronouns (she/her/hers)		
Street Address		
City, State, Zip		
County		
Phone Number		
Email		
Date of Birth (MM/DD/YY)		
Place of Birth (City, State, Country)		
Country of Citizenship		
Race		
LGBTQ (Yes or No)		
Gender Identity		
Religion (if applicable)		
Marital Status		
If Married: Date & Country of Marriage		
Job Title & Employer		
Annual Salary		
Highest Level of Education		

FAMILY

Annual Household Income _____

Net Worth (assets minus debts) _____

History of Bankruptcy ☐ Yes Dates: _____ ☐ No

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

Health Insurance Provider _____

CHILDREN

FIRST & LAST NAME	BIRTH DATE	GENDER IDENTITY	RACE	RELATIONSHIP
1. _____	_____	_____	_____	☐ Adopted ☐ Birth
Current Living Arrangement _____				☐ Foster
2. _____	_____	_____	_____	☐ Adopted ☐ Birth
Current Living Arrangement _____				☐ Foster
3. _____	_____	_____	_____	☐ Adopted ☐ Birth
Current Living Arrangement _____				☐ Foster

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

OTHERS LIVING IN HOME

FIRST & LAST NAME	BIRTH DATE	GENDER IDENTITY	RELATIONSHIP
1._____	_____	_____	_____
2._____	_____	_____	_____

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 or Death	_____	_____
Reason for Ending	_____	_____
2. Date of Divorce or Death	_____	_____
Reason for Ending	_____	_____
3. Date of Divorce or 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.

MEDICAL

	APPLICANT 1	APPLICANT 2
Height	_____	_____
Weight	_____	_____
Have you ever been hospitalized?	☐ Yes ☐ No	☐ Yes ☐ No
Do you currently have, or have a history of, disease and/or chronic conditions?	☐ Yes ☐ No	☐ Yes ☐ No

If yes, please attach the following: date of diagnosis, prognosis, and impact on ability to parent.

Have you undergone infertility treatment?	☐ Yes ☐ No	☐ Yes ☐ No
Have you ever received counseling or therapy of any kind?	☐ Yes ☐ No	☐ Yes ☐ No

If yes, please list the dates of duration, and reason for therapy:

Have you ever been treated for any mental health conditions (such as depression, anxiety, etc.)?	☐ Yes ☐ No	☐ Yes ☐ No

If yes, please attach the following: date of service, diagnosis and prognosis.

Please list any prescription medication you've taken in the past two years, including start/end dates and condition treated.	

Note: a doctor's and/or therapist's letter may be required.

If you have additional medication to list, please include in an attached document.

BACKGROUND HISTORY AFFIDAVIT

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

	APPLICANT 1	APPLICANT 2
Child Protection Matters	☐ Yes ☐ No	☐ Yes ☐ No
Have you ever had a child removed from your home?	☐ 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 send additional details including date, location, charges, fines and/or disciplinary action. If applicable, include terms of sentence, probation and/or dates of incarceration.

FOSTER CARE/ADOPTION INFORMATION

Have you previously completed a home study? ☐ Yes Name of Agency: _____ ☐ No

If you have previoulsy 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 dissolved, denied, or disrupted? ☐ Yes ☐ No

Have you already identified a home study or placing agency other than CH/LSS for this adoption? ☐ Yes ☐ No

If yes, name of agency: _____

Agency contact (name, email, phone): _____

Are you currently matched to a child or expectant parent? ☐ Yes ☐ No

If yes, please list the child's birth date or anticipated birth date: _____

PROGRAM INTEREST

Please check all that apply:

☐ International Adoption (Open to families throughout the U.S.):

☐ China ☐ Colombia ☐ Colombia Hosting ☐ Ecuador ☐ India ☐ South Korea

☐ International Relative/Identified Adoption Only:

☐ Dominica ☐ Grenada ☐ Honduras ☐ Jamaica ☐ St. Vincent & the Grenadines

☐ Domestic Infant Adoption (MD, MN, & VA families only)

☐ Foster Care (MN families only)

☐ Foster Care Adoption (MN families only)

☐ Home Study and/or Post Placement Only (no placement services) (MD, MN, VA & WI families only)

OPENNESS TO CHILDREN AND NEEDS

Will you consider siblings? ☐ Yes Number of siblings: _____ ☐ No

Indicate the age range of children you are open to: _____

Indicate the sex of the child(ren) you are open to: _____ No preference

Will you consider children with identified needs? ☐ Yes ☐ No

If yes, indicate the level of needs you are open to: ☐ Minor ☐ Moderate ☐ Significant/Lifelong

AUTHENTICATION

Misrepresentation may affect our ability to provide services.

I hereby verify that I have truthfully answered all of the questions on the Application Part 1:

APPLICANT 1 | Signature _____ Date _____

APPLICANT 2 | Signature _____ Date _____

**Note, you are not a client of CH/LSS until a service contract is complete.*