

**THE NAVAJO NATION
DIVISION OF SOCIAL SERVICES
ADOPTION APPLICATION**

ATTACH PHOTO HERE
(OPTIONAL)

PLEASE COMPLETE & ANSWER ENTIRE FORM

I. IDENTIFYING INFORMATION:

Home Telephone: _____ Business Telephone: _____ (Applicant 1)
Cell Phone (optional): _____ (Applicant 2)

Present Address: _____ How Long? _____
Previous Address: _____ How Long? _____
Directions to Home: _____

APPLICANT 1:

Full Legal Name: _____ Date of Birth: _____
Other Name(s) Used: _____ Marital Status: _____
Enrollment #: _____ Tribe: _____ Place of Birth: _____
Maternal Clan: _____ Paternal Clan: _____
Social Security Number: _____ Ethnic Origin: _____
Date of Marriage: _____ Place of Marriage: _____

APPLICANT 2:

Full Legal Name: _____ Date of Birth: _____
Other Name(s) Used: _____ Marital Status: _____
Enrollment #: _____ Tribe: _____ Place of Birth: _____
Maternal Clan: _____ Paternal Clan: _____
Social Security Number: _____ Ethnic Origin: _____
Date of Marriage: _____ Place of Marriage: _____

OTHER HOUSEHOLD MEMBERS: (Any other Persons Living In the Household)

Name	Relationship	DOB	Sex	Census #	Occupation	Grade (School)

II. MOTIVATION FOR ADOPTION:

Our family became interested in adoption when.....and we feel our family would make a good adoptive family because....

III. PERSONAL HISTORY:

APPLICANT'S (1) PREVIOUS SPOUSE: (Marital History)

Name of Spouse: _____ Date of Marriage: _____
 Place of Marriage: _____ Date of Divorce/Death: _____

APPLICANT'S (2) PREVIOUS SPOUSE: (Marital History)

Name of Spouse: _____ Date of Marriage: _____
 Place of Marriage: _____ Date of Divorce/Death: _____

If Ethnic Origin is Alaska Native or Native American, please answer the following:

RELATIVES: (List Parents, Siblings and Significant Others)

Name	Related to Father/Mother	Age	Address

CHILDREN OUT OF HOME:

Name	DOB	Census #	Occupation	Current Resident	Marital Status

CRIMINAL RECORD:

Have you or any member of your household been arrested or convicted of a criminal action and/or currently on probation or parole? () Yes () No

Have you or any member of your household been investigated for child physical abuse, sexual abuse, or neglect? () Yes () No

If you answered yes to the questions above, please explain.

Date	Charge	Arresting Agency	Location	Disposition

EDUCATIONAL HISTORY: (Circle highest grade in each row)

APPLICANT 1:

Grade School: 1 2 3 4 5 6 7 8
 High School: 9 10 11 12

APPLICANT 2:

Grade School: 1 2 3 4 5 6 7 8
 High School: 9 10 11 12

High School Name: _____

High School Name: _____

Graduation Date: _____

Graduation Date: _____

College Training: 1 2 3 4 4+

College Training: 1 2 3 4 4+

Degree Received: _____

Degree Received: _____

Last College/University Attended and Address:

Last College/University Attended and Address:

Other Training Certificates:

Other Training Certificates:

MILITARY STATUS:

Name of household members whose a Veteran: _____

Active: _____ Discharge: _____ Reserve: _____

Branch: () Air Force () Army () Coast Guard () Marines () Navy () National Guard

FAMILY HEALTH HISTORY:

APPLICANT 1:

APPLICANT 2:

Yes or No

HAVE YOU EVER BEEN TREATED FOR:

Yes or No

() ()

Arthritis

() ()

() ()

Tuberculosis

() ()

() ()

Asthma, emphysema, or other respiratory illness

() ()

() ()

Heart Disease

() ()

() ()

Eating Disorder

() ()

() ()

Ulcers

() ()

() ()

Diabetes

() ()

() ()

Recurrent Headaches or migraines

() ()

() ()

Seizure Disorders/Epilepsy

() ()

() ()

Cancer

() ()

() ()

Physical disability, including birth defects

() ()

() ()

Amputation

() ()

() ()

Blood Disease/Blood Borne Disease/Hepatitis A/B/C

() ()

() ()

Communicable Disease

() ()

() ()

Hearing Impairment

() ()

() ()

Blindness, Eye Disease, or vision impairment

() ()

() ()

Kidney Disease/Renal Failure

() ()

() ()

Sexual Transmitted Disease

() ()

() ()

Are you presently taking medication?

() ()

() ()

Have you ever had surgery?

() ()

() ()

Have you ever been hospitalized? (Not for childbirth)

() ()

() ()

Do you have any allergies?

() ()

() ()

Have you ever been tested for HIV?

() ()

For any yes answer, please complete the following:

APPLICANT 1:

APPLICANT 2:

Condition _____ Date _____
Treatment/Medication and Results

Condition _____ Date _____
Treatment/Medication and Results

Condition _____ Date _____

Condition _____ Date _____

Treatment/Medication and Results:

Treatment/Medication and Results:

ALCOHOL AND TOBACCO USE:

- 1. Do you or any household member(s) consume alcohol? If so, how often. _____
If yes, how is the alcoholic beverage stored? _____
- 2. Do you or any household member(s) smoke cigarettes/cigars? If so, how often. _____
If yes, how do you plan to prevent second hand smoke exposure? _____
- 3. Do you or any household member(s) chew tobacco? If so, how often. _____

MENTAL HEALTH HISTORY:

- 1. Previous mental health treatment (including counseling, self-help, spiritual help, etc.)
Mental Health Counseling _____
Substance Abuse Counseling _____
And/Or Treatment (i.e. Anger Management/ Marriage/Domestic Violence Counseling) _____
Spiritual Counseling _____
- 2. Has anyone in your household ever been hospitalized for psychiatric and/or mental health related issues (voluntarily/involuntarily)? If yes, please explain. _____
- 3. Has anyone in your household ever had a psychological evaluation? If yes, please explain. _____
- 4. Has anyone in your household ever or currently taking any psychotropic medication for mental illness? If yes, please explain. _____
- 5. Has anyone in your household had suicidal ideation? If yes, please explain. _____
- 6. Have you or anyone in the household refused medical/mental health treatment? If yes, please explain. _____
- 7. Anyone in your household has a gambling addiction? _____

IV. FINANCIAL HISTORY:

EMPLOYMENT HISTORY: (List last three (3) employments)

APPLICANT 1:

Occupation	Employer Name/Address	Dates (Mo/Yr)	Annual Salary	Reason for Leaving

APPLICANT 2:

Occupation	Employer Name/Address	Dates (Mo/Yr)	Annual Salary	Reason for Leaving

INCOME:

MONTHLY AMOUNT:

\$ _____ APPLICANT'S 1 Gross Pay
 \$ _____ APPLICANT'S 2 Gross Pay
 Other Income (Child Support, Adoption Subsidy, and/or Other Source)
 \$ _____ for _____
 \$ _____ for _____
 \$ _____ TOTAL MONTHLY HOUSEHOLD INCOME

EXPENSES:

List Average Monthly Expenses:

\$ _____ Mortgage/Rent Payment
 \$ _____ Utilities: Gas/Electric/Water
 \$ _____ Phone
 \$ _____ Food
 \$ _____ Clothing
 \$ _____ Medical/Dental Care
 \$ _____ Child Support
 \$ _____ Recreation/Entertainment
 \$ _____ Charitable Contributions
 \$ _____ Car Maintenance/Fuel
 \$ _____ Vehicle Payment(s)
 \$ _____ Vehicle Insurance
 \$ _____ Revolving Charge Accounts
 \$ _____ Life Insurance
 \$ _____ Medical Insurance:
 \$ _____ Other: _____
 \$ _____ TOTAL MONTHLY EXPENSES

Have you ever file bankruptcy proceedings? () Yes () No

(If yes, complete the following):

Date Filed: _____

Date Closed: _____

Place Filed: _____

OTHER RESOURCES AND ASSETS:

Family Residence: () House () Apartment () Mobile Home () Other

Description of Home: _____

Automobile(s)	Make	Year	Date of Final Payment
Boat/RV:			
Mobile Home:			

Bank Accounts: Checking Account () Yes () No
 Saving Account () Yes () No
 Stocks/Bonds () Yes () No
 Retirement Accounts: () Yes () No

INSURANCE:

Name of Insured	Company	Type of Insurance	Amount	Beneficiary

V. LIFESTYLE:

RELIGIOUS AFFILIATION:

What is your religious preference?

COMMUNITY/NEIGHBORHOOD:

Tell us about your neighborhood. (Is your home located on or off Indian Reservation? Is your home in the city or in the rural area? . . .)

Tell us about the schools. (Is there public or private schools? How far are they located from the home? How do the children get there? . . .)

Tell us about the clinic and hospitals. (Are the facilities private or are they Indian Health Services?)

Tell us about the social services provided in your home area. How far do you have to travel to obtain counseling services, if needed?

SOCIAL / CULTURAL ACTIVITIES:

What type of social activities does your family participate in? How often?

What type of traditional/cultural events does your family participate in? How often?

Do any members of your family participate in any community organization(s)? If yes, please list the organizations.

VI. DESCRIPTION OF PROSPECTIVE CHILD:

NOTE: PLEASE BE AWARE THAT MOST OF OUR CHILDREN ARE NOT 4/4 NAVAJO AND MOST ARE LIKELY TO BE RACIALLY MIXED.

Which child is most preferred? () Boy () Girl

() Navajo () Navajo/Hispanic () Navajo/Black () Navajo/Anglo

() Navajo/Other Tribe

Are you interested in Special Needs/Disabled children? () Yes () No

Are you interested in adopting sibling groups? () Yes () No

Would you consider open adoption (contact with birth parent(s) or family)? () Yes () No

What age group do you most prefer? () Infant to Age 2 () Age 3 to 5 () Age 6 to 10 () Over age 10

Can you accept a child who has the following behavioral or emotional problems?

	Yes	No	Negotiable		Yes	No	Negotiable
Frequent crying	___	___	___	Temper tantrums	___	___	___
Hyperactive	___	___	___	Bed wetting	___	___	___
Extreme shyness	___	___	___	Extreme fearfulness	___	___	___
Lying	___	___	___	Masturbation	___	___	___
Destructiveness	___	___	___	Swearing, foul language	___	___	___
Stealing	___	___	___	Running away	___	___	___
Aggressive, hostile	___	___	___	Truant	___	___	___
Use of drugs, alcohol	___	___	___	Use of Inhalant	___	___	___
Smoking	___	___	___	Inappropriate sexual activity	___	___	___
Defiant	___	___	___	Fighting with other children	___	___	___
Sexually active	___	___	___	Withdrawn	___	___	___
Sexually abusing others	___	___	___	Mourning family of origin	___	___	___
Mourning foster parents	___	___	___	Cruelty to animals	___	___	___
Fire setting	___	___	___				

Disabilities and Other Special Conditions

	Yes	No	Negotiable		Yes	No	Negotiable
Downs Syndrome	___	___	___	Cast/Broken Bones	___	___	___
Orthopedic	___	___	___	Blind or Partially Blind	___	___	___
Deaf or Hearing Impaired	___	___	___	Sickle Cell Anemia	___	___	___
Mental Retardation Level				Learning Disability	___	___	___
Mild	___	___	___	Diabetes	___	___	___
Moderate	___	___	___	Epilepsy (Seizures DO)	___	___	___
Severe	___	___	___	Heart Defect for Disease	___	___	___
Profound	___	___	___	Autism	___	___	___
Enuresis (wetting Bed/Pants)	___	___	___	Encopresis (Bowel	___	___	___
Asthma	___	___	___	Movement in pants)	___	___	___
Speech Problems	___	___	___	Amputation	___	___	___
Cerebral Palsy	___	___	___	Muscular Dystrophy	___	___	___
Physical Therapy	___	___	___	Psychiatric Care	___	___	___
Developmental Delays	___	___	___	Attachment Problems	___	___	___
Attention Deficit Disorder	___	___	___	Child of Incest	___	___	___
Cystic Fibrosis	___	___	___	Partial Paralysis	___	___	___
Terminal Illness	___	___	___	AIDS	___	___	___
HIV+	___	___	___	Chronic Ear Infection	___	___	___
Orthodontic Problems	___	___	___	Shaken Baby Syndrome	___	___	___
Fetal Alcohol Syndrome	___	___	___	Drug Affected	___	___	___
Scoliosis	___	___	___	Hemophilia	___	___	___
Cleft Palate	___	___	___				

VII. REFERENCES: (Identify three persons for character references: 2 relatives & 1 non-related)

Name	Address (P.O., City, State, Zip)	Phone# (Home/Work)
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Name	Address (P.O., City, State, Zip)	Phone# (Home/Work)
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Name	Address (P.O., City, State, Zip)	Phone# (Home/Work)
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VIII. SIGNATURES (BOTH APPLICANTS):

The above information is true and correct to the best of my knowledge. We hereby authorize the Division of Social Services to make any necessary background investigation to determine eligibility for consideration of being adoptive parents.

Applicant's 1 Signature	Date
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Applicant's 2 Signature	Date
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