Adopt America Network™
Special Children Deserve Special Families

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FAMILY REGISTRATION FORM
(Please type or print)

AAN Adoption Specialist_____

Team Number_____

Date:_____

Applicant #1_____DOB_____M/F_____

Occupation_____Bus. Phone_____

Applicant #2_____DOB_____M/F_____

Occupation_____Bus. Phone_____

Home Phone_____E-Mail_____

Address_____

City_____State_____Zip_____County_____

Marital Status_____Religion_____Languages Spoken_____

Sign Language_____How many children have you raised?_____
(No longer living in the home)

Are there Smokers in the Home?_____Are there Pets in the Home?_____

If Native American, Percentage_____Tribe_____Are you currently registered in a tribe?_____

First Names of Children Living At Home	M/F	DOB	Biological	Adopted	Foster	Mental Physical/Emotional Challenges

Continue list on separate sheet of paper if necessary.

Revised 5/12

*** Used for statistical purposes only**

Please check all types of child(ren) you would consider adopting:

Preferred Race:
___African American
___Asian
___Biracial
___Caucasian
___Hispanic
___Native American
Other_____

Preferred Sex:
___Female
___Male
___Either

Preferred Age:
___0 - 6 yrs.
___7 - 10 yrs.
___11 - 14 yrs.
___15 & over

The **youngest** age child I will consider is:_____
The **oldest** age child I will consider is: _____

How many at this time?
___One
___Two
___Three
___Four
___Any number

Please check the following challenges that you will consider in a child:

___ADD
___ADHD
___Adjustment Disorder
___AIDS/HIV
___Animal Abuse
___Anxiety Disorder
___Asthma
___Attachment Disorder
___Autism
___Bi-polar
___Blind
___Cerebral Palsy/Mild
___Cerebral Palsy/Moderate
___Cerebral Palsy/Severe
___Conduct Disorder
___Deaf
___Depression
___Developmental Delays
___Diabetes
___Down Syndrome
___Drug Exposed
___Eating Disorders
___Emotional/Mild
___Emotional/Moderate
___Emotional/Severe
___Encopresis
___Enuresis
___Epilepsy
___Failure to Thrive
___Fetal Alcohol Syndrome
___Fire Starter
___Heart Murmur
___Hydrocephalic
___Hyperactivity
___Learning Disability
___Legal Risk
___Macrocephalic
___Mental Retardation/Mild
___Mental Retardation/Moderate
___Mental Retardation/Severe
___Microcephalic
___Missing Limbs
___Mood Disorder
___Muscular Dystrophy
___Non-Ambulatory
___Non-Verbal
___Obsessive Compulsive Disorder
___Oppositional Defiant Disorder (ODD)
___Paralysis
___Physically Abused
___Physically Aggressive
___Post Traumatic Stress Disorder (PTSD)
___Quadriplegia
___Reactive Attachment Disorder (RAD)
___Run Away
___Schizophrenia
___Scoliosis
___Seizures
___Self Abusive
___Sexually Abused
___Sexually Acting Out
___Shaken Baby Syndrome
___Sickle Cell
___Spina Bifida
___Terminal Illness
___Total Care
___Tourette Syndrome
___Trach
___Tube Fed
___Other Conditions, Syndromes, Problems (Please List)

_____

_____

_____

Describe any skills, knowledge, or experience with special needs children you may have: _____

_____

_____

_____

Describe any conditions or behaviors you cannot accept:_____

_____

_____

_____

Please give us a brief description of your family, your lifestyles, your interests, etc. Please attach a snapshot or color copies of photos of your family. (If more space is needed, please use a separate sheet):

ATTACH FAMILY PHOTO HERE

Has Adopt America Network (AAN) assisted to you in any way for any of your adopted children? yes☐ no☐

If yes, which child(ren)? _____

Have you completed an **adoption** (not foster) **home study** and have been approved for adoption? yes☐ no☐

Date _____ Are you licensed for foster care? yes☐ no☐

If no, are you in a home study now? yes☐ no☐ Expected date of completion: _____

SOCIAL WORKER AND AGENCY INFORMATION MUST BE COMPLETE IF APPLICABLE (SIGNATURE(S) ARE REQUIRED)

Name of Social Worker: **Joe Haynes** Phone **864-908-4157**

E-Mail **adoptadv@msn.com**

Name of Agency: **Adoption Advocacy, Inc.**

Address of Agency **PO Box 406**

City **Easley** State **SC** Zip **29641**

I (we) hereby authorize the above agency to release my adoption home study to Adopt America Network. This also authorizes Adopt America Network to send our (my) Home Study out to child agencies on our (my) behalf.

_____ _____

Signature Applicant #1 Signature Applicant #2

(Office Use Only)

_____ (Date)	**Approved for Home Study Grant**	_____ (Name of Agency)
_____ (Date)	**Approved for Update Grant**	_____ (Name of Agency)
_____ (Date)	**Assigned to Team for Matching**	_____ (Team Leader)