

The information you provide on this form is collected under the authority of the *Child, Youth and Family Enhancement Act* and is managed in compliance with the *Freedom of Information and Protection of Privacy (FOIP) Act*. The information will be used to process your application to adopt a child. We will not release this information for any other purpose. If you have any questions about the collection of this information, you may contact your caseworker.

1. Applicant's Name (surname/first/middle)		
Previous or other surname	Birthdate (yyyy/mm/dd)	Telephone Number
Address <i>Apt.#, Street</i>		
City/Town	Province	Postal Code
Racial Origin	Aboriginal Type	Ethnic Origin
If Registered Indian, Band Name and Registration Number		If Metis, Metis Settlement or Community
Religion	Practising <input type="checkbox"/> yes <input type="checkbox"/> no	Education
Occupation		
Place of Employment		Business Telephone Number

2. Co-applicant's Name (Surname/First/Middle)		
Previous or other surname	Birthdate (yyyy/mm/dd)	Telephone Number
Racial Origin	Aboriginal Type	Ethnic Origin
If Registered Indian, Band Name and Registration Number		If Metis, Metis Settlement or Community
Religion	Practising <input type="checkbox"/> yes <input type="checkbox"/> no	Education
Occupation		
Place of Employment		Business Telephone Number

3. Marital Status
 Single Married Adult Interdependent Relationship Separated Divorced

4. Have you ever received services from Child Intervention Services? yes no

5. Have you ever applied to adopt or foster before? yes no

6. Children Name as per Birth Registration	Gender		Adopted		Birthdate yyyy/mm/dd	Grade	Name of School/Occupation
	M	F	yes	no			

If child is adopted, please indicate ethnic/racial origin

7. Other persons currently living in your home Name	Birthdate yyyy/mm/dd	Relationship

8. Family Health (Please give particulars of any major operations, chronic conditions or psychiatric consultations.)

9. Child Desired
 Male Female Either
 Age Range From _____ to _____

Family Group: Indicate number of children, age range and gender
 Number of children _____ Males Females Either
 Age Range - From _____ to _____

Racial origin:
 001 Caucasian 002 Aboriginal 004 Black 005 Oriental 006 East Indian
 007 Mixed Race (specify) _____ 008 Any

Aboriginal type:
 001 Status Indian 002 Potential to be registered 003 Non Status Indian
 004 Inuit 005 Metis 006 Any

If special needs child acceptable, please specify below:

- | | | |
|--|---|--|
| 002 <input type="checkbox"/> Developmentally delayed | 003 <input type="checkbox"/> Mentally handicapped | 004 <input type="checkbox"/> Fetal Alcohol Spectrum Disorder |
| 005 <input type="checkbox"/> Down's Syndrome | 006 <input type="checkbox"/> Hearing/visually impaired | 007 <input type="checkbox"/> Behavioural/emotional issues |
| 008 <input type="checkbox"/> Psychiatric diagnosis | 009 <input type="checkbox"/> Legal risk | 010 <input type="checkbox"/> Learning disability/special education |
| 011 <input type="checkbox"/> Cerebral Palsy | 012 <input type="checkbox"/> Speech delays/impediments | 013 <input type="checkbox"/> Diabetes |
| 014 <input type="checkbox"/> Epilepsy | 015 <input type="checkbox"/> Sexual abuse | 016 <input type="checkbox"/> Physical abuse |
| 017 <input type="checkbox"/> Sibling contact | 018 <input type="checkbox"/> Birth parent contact | 019 <input type="checkbox"/> Permanent disability |
| 020 <input type="checkbox"/> Cleft palate | 021 <input type="checkbox"/> Premature | 022 <input type="checkbox"/> Difficult delivery |
| 023 <input type="checkbox"/> Multiple placements | 024 <input type="checkbox"/> Heart disorders | 025 <input type="checkbox"/> General medical needs |
| 026 <input type="checkbox"/> Neglect | 031 <input type="checkbox"/> Permanent Placement Disruption | 033 <input type="checkbox"/> Fetal Alcohol Effect |
| 034 <input type="checkbox"/> Fetal Drug Effect | 035 <input type="checkbox"/> Failure to Thrive | 036 <input type="checkbox"/> Spina Bifida |
| 037 <input type="checkbox"/> HIV Risk | 038 <input type="checkbox"/> HIV Positive | 039 <input type="checkbox"/> Attention Deficit Disorder & Hyperactive Disorder (ADD) |
| 040 <input type="checkbox"/> Hepatitis C | | |

Family Background:

- | | | |
|---|--|---|
| 000 <input type="checkbox"/> Unknown background | 001 <input type="checkbox"/> Inheritable diseases | 002 <input type="checkbox"/> Psychiatric diagnosis - birth parents |
| 003 <input type="checkbox"/> Learning disorders | 004 <input type="checkbox"/> Drug abuse during pregnancy | 005 <input type="checkbox"/> Alcohol abuse during pregnancy |
| 006 <input type="checkbox"/> Born as result of sexual assault | 007 <input type="checkbox"/> Born as result of incest | 009 <input type="checkbox"/> History of Global Developmental Delays |
| 010 <input type="checkbox"/> Abuse of Drugs/Alcohol by Birth Father | | |

Are you applying for a specific child(ren)?

yes no → **If yes, please complete the following:**

Child(ren)'s Name

1. _____ | 2. _____

If this adoption does not proceed, would you be interested in fostering or adopting other children?

Yes No

Are you willing to maintain contact with:

siblings birth mother birth father extended family band members

How did you first learn about this child?

Internet Wednesday's Child Newspaper Newsletter Adoption Fair
 Other _____

Are you willing to be involved with and maintain a child's culture through:

involvement with cultural groups and organizations.
 contact with the Band with a view to participating in cultural activities on the Reserve or Settlement.

10. Please give the names and addresses of three (3) persons per applicant, one of whom is a relative. The same reference may be given for both applicants if the person knows both applicants and is willing to share information when contacted.

Name	Telephone Number
Address	Postal Code
Name	Telephone Number
Address	Postal Code
Name	Telephone Number
Address	Postal Code
Name	Telephone Number
Address	Postal Code
Name	Telephone Number
Address	Postal Code
Name	Telephone Number
Address	Postal Code

11. Certification

I/We declare:

1. that the information contained in this application is complete and true to the best of my/our knowledge and that a false statement may disqualify my/our application from further consideration.
2. an acknowledgment that the Ministry of Children's Services will check the Intervention Record System for any information relevant to this application and that a criminal record check will also be required. (The existence of a criminal record will not necessarily result in an exclusion from the program).
3. that the Ministry of Children's Services is given permission to contact the references named on this application and the school where my/our children are in attendance.

Signature of Applicant	date (yyyy/mm/dd)
Signature of Co-Applicant	date (yyyy/mm/dd)

For Office Use Only		
Date returned (yyyy/mm/dd)	Facility I.D. Number	Worksite Name