



"IMPROVING THE LIVES OF CHILDREN"

Parenting Application

Adoption

Foster Care

Adoption and Foster Care

Women's Name (First, Middle, Last)	Maiden (other names)	Man's Name (First, Middle, Last)
Residence Address (Street, City, State, Zip)		County
Home Phone No.	Work Phone: Woman	Work Phone: Man
Mailing Address		School District
Directions to the Home		

Personal Information

Please provide information for you and your spouse:

	Woman	Man
Date of Birth		
Place of Birth		
Citizenship-Are you a US Citizen? If no, where is your citizenship? Are you a permanent Resident Alien? If yes, how long?	<input type="checkbox"/> yes <input type="checkbox"/> No <input type="checkbox"/> yes <input type="checkbox"/> No <input type="checkbox"/> NA years, months	<input type="checkbox"/> yes <input type="checkbox"/> No <input type="checkbox"/> yes <input type="checkbox"/> No <input type="checkbox"/> NA years, months
Social Security Number		
Driver's License Number		
How long have you lived in Texas?		
Racial or Ethnic Background?		
What languages do you speak?		
Mental Health: List all psychological and/or psychiatric treatment and medications		
Health: List all disabilities, serious illnesses, operations, and chronic conditions you have experienced during the past ten years. Also list all the medications you are now taking		

INTERESTS: TYPES OF CHILDREN

Describe the type of child(ren) for which you are interested in providing adoption and/or foster care services.

Number	Sex			Age Range	Races/Ethnicities (Check those that apply)		
	<input type="checkbox"/> Boy	<input type="checkbox"/> Girl	<input type="checkbox"/> Either		<input type="checkbox"/> Anglo <input type="checkbox"/> Asian <input type="checkbox"/> Other	<input type="checkbox"/> Black <input type="checkbox"/> Native American	<input type="checkbox"/> Hispanic

Which of the following special needs can you work with by using your family's abilities and strengths?

<input type="checkbox"/> Adopted Previously	<input type="checkbox"/> Enuresis/Encopresis	<input type="checkbox"/> Learning Disabled	<input type="checkbox"/> Self Abuse
<input type="checkbox"/> ADD/ADHD: Diagnosed	<input type="checkbox"/> Failure to Thrive	<input type="checkbox"/> Limited English Proficiency	<input type="checkbox"/> Sexual Acting Out
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Fire Setting History	<input type="checkbox"/> Medically Fragile	<input type="checkbox"/> Sexual Transmitted Diseases
<input type="checkbox"/> Animal Cruelty History	<input type="checkbox"/> Gang Activity/Affiliation	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Sibling Group
<input type="checkbox"/> Assaultive Behavior	<input type="checkbox"/> Health Disabled	<input type="checkbox"/> Military Dependent	<input type="checkbox"/> Speech Disabled
<input type="checkbox"/> Developmentally Delayed	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Mobility Impaired	<input type="checkbox"/> Teen Parent
<input type="checkbox"/> Downs Syndrome	<input type="checkbox"/> HIV Positive/AIDS	<input type="checkbox"/> Physically Disabled	<input type="checkbox"/> Terminal Illness
<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Infant Alcohol Addiction	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Visually Impaired
<input type="checkbox"/> Emotionally Disturbed	<input type="checkbox"/> Infant Drug Addiction	<input type="checkbox"/> Runaway	<input type="checkbox"/> Other Behavior Problem
			<input type="checkbox"/> None

Comment about your family's abilities or strengths on any of the boxes checked: _____

MARITAL INFORMATION

Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		NOTE: If you are married, both you and your spouse must apply together, and you must attach a copy of your marriage license or declaration of marriage.
Date of Marriage	Place of Marriage (City, State, Country)	County

Woman's previous marriages (If more than three, use a separate piece of paper. Also, please attach a copy of each death certificate or divorce decree.)

Name of Previous Spouse	Dates of Marriage (From - To)	How Ended	Recording of Divorce (County and State)
		<input type="checkbox"/> Divorce <input type="checkbox"/> Death	
		<input type="checkbox"/> Divorce <input type="checkbox"/> Death	
		<input type="checkbox"/> Divorce <input type="checkbox"/> Death	

Man's previous marriages (If more than three, use a separate piece of paper. Also, please attach a copy of each death certificate or divorce decree.)

Name of Previous Spouse	Dates of Marriage (From - To)	How Ended	Recording of Divorce (County and State)
		<input type="checkbox"/> Divorce <input type="checkbox"/> Death	
		<input type="checkbox"/> Divorce <input type="checkbox"/> Death	
		<input type="checkbox"/> Divorce <input type="checkbox"/> Death	

OTHER HOUSEHOLD MEMBERS

List the other members of your household (if more spaces are needed, use another sheet of paper):

Name	Sex	Relationship	Date of Birth	Identification Numbers	Health
				Social Sec. Driver's Lic.	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
				Social Sec. Driver's Lic.	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
				Social Sec. Driver's Lic.	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
				Social Sec. Driver's Lic.	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
				Social Sec. Driver's Lic.	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
				Social Sec. Driver's Lic.	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

Does anyone in the household have a serious illness, a disability, a chronic problem, or an emotional or nervous condition? Yes No

If "Yes," describe the problem, who it affects and since when? (Give dates: describe the medical treatment and/or counseling)

CHILDREN LIVING OUTSIDE THE HOUSEHOLD

List the names of any of your children or your spouse's children who live outside your household. Include children who are now adults. (NOTE: The department will contact your adult children as references.)

Name	Sex	Age	Address	Telephone Number	WHOSE CHILD?	
					Husband	Wife

BACKGROUND CHECKS

Have you provided or applied to provide foster care before? Yes No

If "Yes," what agency did you work with? (provide name, address and telephone number).

Have you ever before applied to adopt a child? Yes No

If "Yes," what agency did you work with? (provide name, address and telephone number).

If you answered "Yes," to either of the two preceding questions, may we contact the agency?

Yes No

Grace Manor, through the Texas Department of Protective and Regulatory Services, Checks criminal history files of the Texas Department of Public Safety and the Federal Bureau of Investigation (FBI) and may check Criminal history files with local law enforcement agencies. TDPRS will also check its own files to determine whether any adults in your household have been reported for child abuse or neglect. In addition, TDPRS may check driving records for all household members with driver's licenses.

Have you or any members of your household ever been convicted of, or are currently facing charges for, any criminal offense?

Yes No

Have you or any members of your household ever been investigated for child abuse or neglect?

Yes No

Have you, your spouse or any adult household member lived outside of Texas in the last three years?

Yes No

EMPLOYMENT

Provide the following information about your employment:

WOMAN	
Occupation	
Employer	
Employer Address (Street/P.O. Box, City, State, ZIP)	
Employment Date	Life Insurance Amount
Do you have health insurance? If "Yes," what company? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will your health insurance cover an adopted child? <input type="checkbox"/> Yes <input type="checkbox"/> No	

MAN	
Occupation	
Employer	
Employer Address (Street/P.O. Box, City, State, ZIP)	
Employment Date	Life Insurance Amount
Do you have health insurance? If "Yes," what company? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will your health insurance cover an adopted child? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Mother's Work Schedule	
From:	To:
Days per Week	Total Hours per Week

Father's Work Schedule	
From:	To:
Days per Week	Total Hours per Week

CHILD-CARE AND SCHOOL

If both parents are currently employed, what child-care arrangements do you now have in place? _____

What child-care arrangements will you make for children placed in your home? _____

What schools will the child(ren) placed with you attend? _____

INCOME AND EXPENSES

Provide the following information about your financial status:

(NOTE: Please attach paycheck stubs or copies of your most recent tax returns or other documentation of your monthly income.)

Monthly Income

Woman's Income Source: <input type="checkbox"/> Employment <input type="checkbox"/> Retirement Benefits <input type="checkbox"/> Other	Gross \$	Net \$
Man's Income Source: <input type="checkbox"/> Employment <input type="checkbox"/> Retirement Benefits <input type="checkbox"/> Other	Gross \$	Net \$
All Other Household Income Source: Rental Income, Alimony, Child Support, Dividends, Adoption Assistance, Foster Care Reimbursement, etc.	Gross \$	Net \$
TOTAL:		\$

Assets

Specify Sources (Stocks, Bonds, Savings, Investments, Interest Bearing Accounts, etc.)	Value \$
Do you own your own home or do you rent? <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Other (explain)	

Household Expenses

Enter your household's average monthly expenses for the following items. DO NOT INCLUDE EXPENSES THAT ARE DEDUCTED FROM PAYCHECKS.

House/Rent Payments	\$ _____	Automobile Insurance	\$ _____
Payments for Other Real Property	_____	Life Insurance	_____
Automobile Payments	_____	Medical and Dental Insurance	_____
Gasoline and Auto Maintenance	_____	Child Care	_____
Telephone	_____	Child Support Payments	_____
Groceries and Household Supplies	_____	Utilities	_____
Medical Care (Not covered by Insurance)	_____	Other Debts/Expenses (specify)	_____
Dental Care (Not covered by Insurance)	_____		_____
Clothing	_____		_____
Recreation and Entertainment	_____	TOTAL MONTHLY EXPENSES:	\$ _____

MOTIVATION

Explain briefly why you want to be foster/adoptive parents for children with special needs: _____

REFERENCES

List three references who have known you for more than a year, have visited in your home, and can be contacted by the Department. DO NOT LIST RELATIVES HERE.

Name	Address	Telephone No.	Relationship	Years Known
1.				
2.				
3.				

List two relatives whom the department may contact as references. DO NOT LIST ADULT CHILDREN HERE.

Name	Address	Telephone No.	Relationship	Years Known
1.				
2.				

CHILD TRANSPORT

When necessary, can you or someone in the household usually take children to counseling sessions, doctor visits, school meetings, parental visitation (if appropriate), and so forth? Yes No

If "Yes," how will you transport children? _____ If "No," who can? _____

Are child-safety seats and seat belts available in the vehicle? Yes No N/A

If "No," or "N/A," how will you transport children safely? _____

Please enclose photographs of your family and your home. Include all family members, pets and foster or adoptive child's bedroom. (You may send the photographs later if they are not currently available.)

My signature verifies that the information contained on this application is true and correct to the best of my knowledge and that I agree to abide by the Texas Department of Regulatory Services policy prohibiting physical discipline of children in the conservatorship of TDPRS. I understand with this application that Grace Manor, through TDPRS, will conduct criminal history checks, child abuse and neglect checks, and may acquire a certified copy of my driving record. I grant Grace Manor and the Texas Department of Protective and Regulatory Services permission to make inquiries and/or consultations with law enforcement agencies to verify the above information, check child abuse records, and receive a certified copy of my driving record from the Texas Department of Public Safety.

Signature - Woman

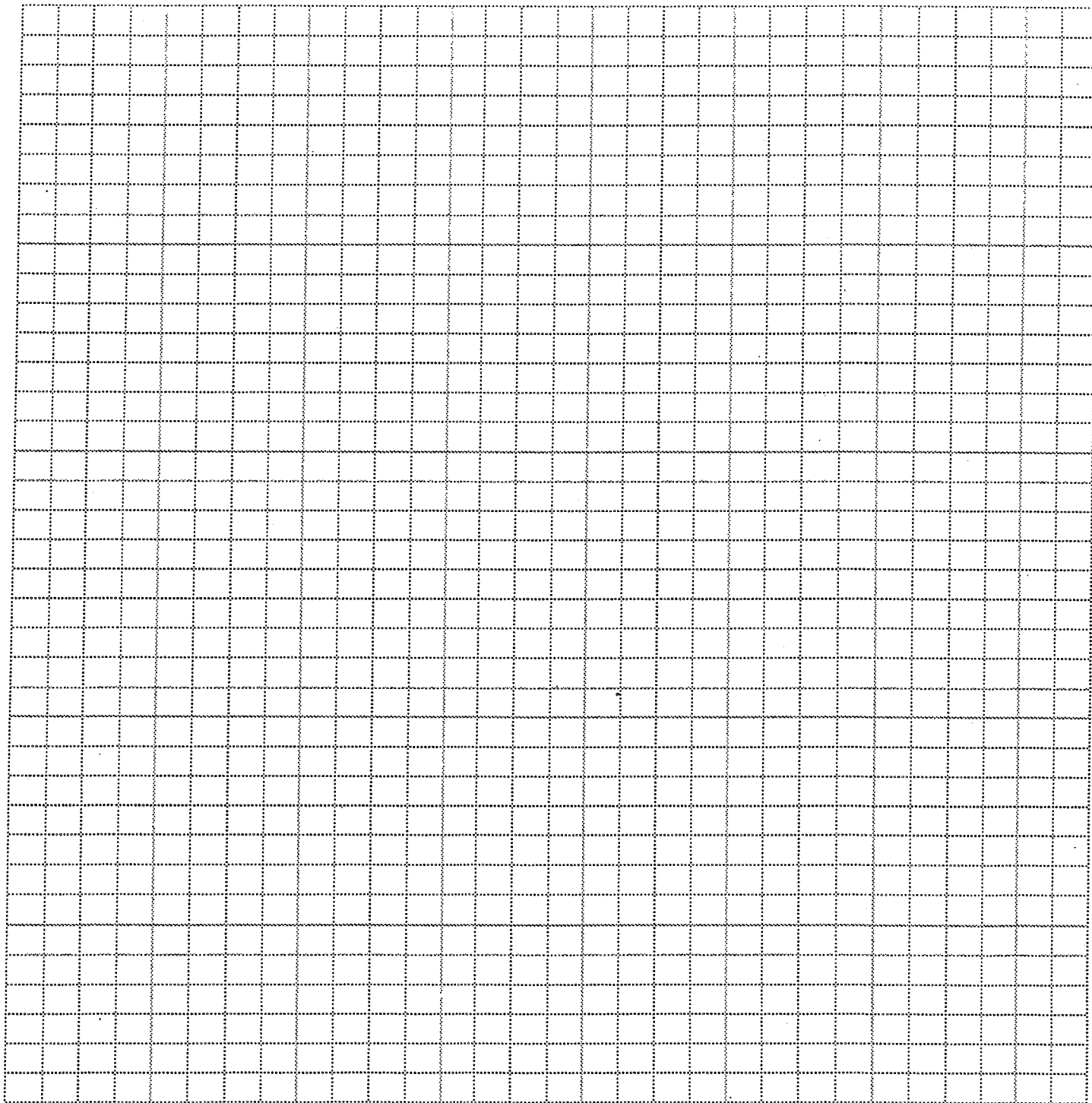
Date

Signature - Man

Date

Foster/Adoptive Family Name: _____

Please sketch the floor plan of your home. Indicate the size (square feet) and purpose of each room, specify where each household member sleeps, and show the bedroom(s) designated for the foster or adoptive child(ren).



Address of Home: _____

Date _____