



APPLICATION: ADOPT ONLY

Thank you for your time and effort in thoroughly completing this application and providing truthful and detailed answers so that we may properly review, consider, and represent your family. By being complete and with appropriate elaboration in your responses on these instruments, we are able to move through the process with less delay, follow-up, and miscommunication. Thank you in advance and we look forward to serving you!

Required documents to be included with the application upon submission:

Applications are considered incomplete and cannot be processed without verification of identity with these listed documents.

- Driver's License or State ID
- Social Security Card

*These documents are required for all household members 14 and older for background check purposes. For minors who do not have an ID, Angelheart will provide a waiver to be signed.

DATE OF APPLICATION:			
Adult 1 (Potential Adoptive Parent 1)		Adult 2 (Potential Adoptive Parent 2)	
Full Legal Name:		Full Legal Name:	
Address:		Address:	
County:		County:	
Home Phone:		Home Phone:	
Cell Phone:		Cell Phone:	
Work Phone:		Work Phone:	
Email:		Email:	
Date of Birth:		Date of Birth:	
Social Security #:		Social Security #:	
Driver's License #:		Driver's License #:	
Race & Citizenship:		Race & Citizenship:	
Religious Preference:		Religious Preference:	
Languages spoken:		Languages spoken:	

KINSHIP HOMES ONLY:

Kinship Worker Name:	
County of Removal:	
Kinship Child Name & Date of Birth:	
Kinship Child Name & Date of Birth:	
Kinship Child Name & Date of Birth:	
Kinship Child Name & Date of Birth:	
Kinship Child Name & Date of Birth:	
Kinship Child Name & Date of Birth:	

HOUSEHOLD MEMBERS:

Please list ALL household members and children currently residing in your home. *This would include any person who is living in your home, including kinship children.*

Name:	
Relationship to Applicant:	
Date of birth:	
Social Security #:	
Driver's License #:	
Phone Number:	
Email:	
Ethnicity:	
Grade Level or Occupation:	
Sleeping Location (i.e. private bedroom, shared bedroom, etc.)	

Name:	
Relationship to Applicant:	
Date of birth:	
Social Security #:	
Driver's License #:	

Phone Number:	
Email:	
Ethnicity:	
Grade Level or Occupation:	
Sleeping Location (i.e. private bedroom, shared bedroom, etc.)	

Name:	
Relationship to Applicant:	
Date of birth:	
Social Security #:	
Driver's License #:	
Phone Number:	
Email:	
Ethnicity:	
Grade Level or Occupation:	
Sleeping Location (i.e. private bedroom, shared bedroom, etc.)	

Name:	
Relationship to Applicant:	
Date of birth:	
Social Security #:	
Driver's License #:	
Phone Number:	
Email:	
Ethnicity:	
Grade Level or Occupation:	
Sleeping Location (i.e. private bedroom, shared bedroom, etc.)	

Name:	
Relationship to Applicant:	
Date of birth:	
Social Security #:	
Driver's License #:	
Phone Number:	
Email:	
Ethnicity:	
Grade Level or Occupation:	
Sleeping Location (i.e. private bedroom, shared bedroom, etc.)	

CHILDREN:

Please list ALL of your children NOT living in your home: *This includes biological, adopted, and step-children not living in your home.*

Name:	
Relationship to Applicant:	
Date of Birth:	
Phone Number:	
E-Mail Address:	
Ethnicity:	
Grade Level/Highest Level Achieved:	
Occupation:	

Name:	
Relationship to Applicant:	
Date of Birth:	
Phone Number:	
E-Mail Address:	
Ethnicity:	
Grade Level/Highest Level Achieved:	
Occupation:	

Name:	
Relationship to Applicant:	
Date of Birth:	

Phone Number:	
E-Mail Address:	
Ethnicity:	
Grade Level/Highest Level Achieved:	
Occupation:	

Name:	
Relationship to Applicant:	
Date of Birth:	
Phone Number:	
E-Mail Address:	
Ethnicity:	
Grade Level/Highest Level Achieved:	
Occupation:	

CURRENT RESIDENCE:

Do you currently rent or own your home?: OWN RENT

If applicable, name of subdivision or apartment complex:

HOUSEHOLD INFORMATION:

How many bedrooms are in your home?:

Does your home have a pool or other bodies of water?: YES NO

Is there a trampoline on your property: YES NO

Do you own or keep any pets in your home?: YES NO

If yes:

Name:	Animal Type:	Breed:

Do you own or keep any weapons (guns/projectiles/knives/swords) in your home?:

YES

NO

If yes:

<u>Weapon Type</u>	<u>Quantity</u>

HISTORY OF RESIDENCE FOR PAST 10 YEARS:

Adult 1

Date (Month & Year)	Locational Address	Reason for Moving

Adult 2

Date (Month & Year)	Locational Address	Reason for Moving

VEHICLES OWNED

Year	Make	Model	Total Number of Seats

RELATIONSHIP HISTORY:

Date of Current Marriage:	
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Adult 1:

<u>Previous Marriages:</u>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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Adult 1:

Spouse's Full Name	Dates of Marriage	Termination Date	Reason for Termination

Adult 1:

Any previous names, including birth name, maiden name, etc.:

Adult 2:

<u>Previous Marriages:</u>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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Adult 2:

Spouse's Full Name	Dates of Marriage	Termination Date	Reason for Termination

Adult 2:

Any previous names, including birth name, maiden name, etc.:

EMPLOYMENT:

Adult 1:		Adult 2:	
Employer:		Employer:	
Position Title:		Position Title:	
Hire Date:		Hire Date:	
Working Days/Hours:		Working Days/Hours:	
In-office, remote, or hybrid:		In-office, remote, or hybrid:	
Travel Requirements:		Travel Requirements:	
Monthly Salary (NET):		Monthly Salary (NET):	
Immediate Supervisor:		Immediate Supervisor:	
Work Phone Number:		Work Phone Number:	

EMPLOYMENT HISTORY: *Please list employment history for the past **ten (10)** years. If you do not have ten years of history, please list the dates and the reason for unemployment. (i.e. school, age, ect.)*

Adult 1:		Adult 2:	
Employer:		Employer:	
Position:		Position:	
Dates of Employment:		Dates of Employment:	
Adult 1:		Adult 2:	
Employer:		Employer:	
Position:		Position:	
Dates of Employment:		Dates of Employment:	

<u>Adult 1:</u>		<u>Adult 2:</u>	
Employer:		Employer:	
Position:		Position:	
Dates of Employment:		Dates of Employment:	
<u>Adult 1:</u>		<u>Adult 2:</u>	
Employer:		Employer:	
Position:		Position:	
Dates of Employment:		Dates of Employment:	
<u>Adult 1:</u>		<u>Adult 2:</u>	
Employer:		Employer:	
Position:		Position:	
Dates of Employment:		Dates of Employment:	

INCOME AND BUDGET:

Total Monthly Household Income (Include any government or other financial resources you receive such as SNAP, WIC, TANF) Please list all in NET amounts.

Source of Income:		Amount:	
Source of Income:		Amount:	
Source of Income:		Amount:	
Source of Income:		Amount:	
Source of Income:		Amount:	
		Total NET Amount:	

MONTHLY HOUSEHOLD EXPENSES

House/Rent Payments	\$	Automobile Insurance	\$
Payments for Other Real Estate Property		Home/Renter's Insurance	\$
Automobile Payments	\$	Life Insurance	\$
Gasoline and Auto Maintenance	\$	Medical and Dental Insurance	\$
Internet Services	\$	Child Care	\$
Telephone/Cell Phone	\$	Child Support Payments	\$
Groceries and Household Supplies	\$	Credit cards Payments	\$
Utilities (electric/water/gas)	\$	Tithes and/or Charitable Contributions	\$
Medical Care (Not covered by Insurance)	\$	Student Loans	\$
Dental Care (Not covered by Insurance)	\$	Recreation and Entertainment	\$
Boat/RV/ATV/trailer payments (specify):	\$	Clothing	\$
Cable/Satellite/Subscription TV/ Streaming Services	\$	Personal or payday loans	\$
Legal (court fees, attorney fees, alimony, etc)	\$	Pet/Animal Expenses	\$
Taxes:	\$	Other Debts/Expenses (specify):	\$
		TOTAL MONTHLY EXPENSES:	\$

EDUCATION:

Adult 1			Adult 2		
Name of High School and/or Highest Grade Completed:		Graduation Date:	Name of High School and/or Highest Grade Completed:		Graduation Date:
Undergraduate:	Degree:	Graduation Date:	Undergraduate:	Degree:	Graduation Date:
Graduate:	Degree:	Graduation Date:	Graduate:	Degree:	Graduation Date:
Graduate:	Degree:	Graduation Date:	Graduate:	Degree:	Graduation Date:

RELEVANT HISTORY:

	<u>ADULT 1</u>	<u>ADULT 2</u>
Have you ever been arrested or convicted of a felony or misdemeanor?:		
If yes, explain:		
Have you ever been reported for abuse or neglect of a child or children?		
If yes, explain:		
Have you ever been convicted of abuse or neglect of a child or children?		
If yes, explain:		
Do you drink alcohol?		
If yes, how much & how often?		
Do you smoke?		
If yes, how much & how often?		

HEALTH STATUS:

Do you currently have health insurance, through employment or other means?

Adult 1: YES NO

Adult 2: YES NO

Has anyone in your household had difficulties in the following areas?

	ADULT 1	ADULT 2
Disorder/Disease of the heart, lungs, liver, pancreas, colon, back, bones, muscles, or joints:	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Disorder/Disease of the digestive system, urinary tract, kidneys, reproductive system, infertility:	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Immune disorder, AIDS, ACR, or chronic lung disorder:	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Stroke, paralysis, leukemia, cancer, tumors, neurological or seizure disorder, arthritis or birth defect:	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Mental, nervous, or behavioral disorder, chemical imbalance, alcoholism, drug abuse, or addiction:	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Diabetes:	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
High Blood Pressure:	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Physical, mental, or emotional disability or disorder:	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

Please provide details for any "YES" answers as follows:

Name	Condition & Diagnosis	Dates	Treatment & Results

Please list any other known serious illnesses, handicaps, chronic conditions, or emotional problems, past or present, for all persons living in the home. (Include their name and condition)

Name	Condition & Diagnosis	Dates	Treatment & Results

Has any adult living in your home ever applied to be a foster parent with a different agency?:

YES

NO

If yes, with what agency?

Date of application:

Have you or any adult living in your home ever been denied foster care license or license?:

YES

NO

If yes, with what agency?:

Reason for denial:

Is your home currently licensed, regulated, approved, or operated by any other agency?:

YES

NO

If yes, with what agency?:

Reason for Transfer:

Identify persons that may provide support to your home, as a caregiver to adoptive children in the event of an unexpected event or crisis such as an illness or disability of an adoptive parent, loss of transportation, or the death of an immediate family member.

Full Name	Relationship	Phone Number	Email

I hereby declare that the information provided by me in this application for foster parent is true, accurate, and complete to the best of my knowledge. I give my permission for any of this information to be verified and understand that if any of this information is found to be inaccurate or false, this may be used to terminate any further consideration of my application. I give my consent for any agencies, employers, companies, friends, or family members to be contacted.

Adult 1

Date

Adult 2

Date

Please send completed application to:

Angelheart-Round Rock	Angelheart-North Richland Hills	Angelheart-Temple	Angelheart -San Antonio
3001 Joe DiMaggio Blvd Ste 1100 Round Rock, Texas 78665	9141 Belshire Drive North Richland Hills, Texas 76182	5252 South 31 st St. Temple, TX 76502	5368 Fredericksburg Road, Building C, Ste 100 San Antonio, Texas 78229
PH: 512-310-9857 FAX 512-310-9531	PH:817-893-5420 FAX 817- 893-5525	PH:254-933-7155 FAX: 254-933-7112	PH: 210-405-0014 FAX: 512-310-9531
Email: sflores@ahkids.org	Email: jwolfe@ahkids.org	Email: cgray@ahkids.org	Email: angelheart.sanantonio@ahkids.org