THE NAVAJO NATION
DIVISION OF SOCIAL SERVICES
NAVAJO CHILDREN AND FAMILY SERVICES
HOME STUDY APPLICATION

ATTACH PHOTO HERE
(OPTIONAL)

PLEASE COMPLETE ENTIRE FORM & SIGN

I. IDENTIFYING INFORMATION:

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

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

APPLICANT 1:

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

APPLICANT 2:

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

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 1 PREVIOUS SPOUSE: (Marital History)
Name of Spouse: _____ Date of Marriage: _____
Place of Marriage: _____ Date of Divorce/Death: _____

APPLICANT 2 PREVIOUS SPOUSE: (Marital History)
Name of Spouse: _____ Date of Marriage: _____
Place of Marriage: _____ Date of Divorce/Death: _____

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

Name	Relationship	DOB / Age	Gender	Census #	Occupation	Grade (School)

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

APPLICANT 1 - RELATIVES (List Parents, Siblings and Significant Others):

Name	Related to Applicant 1	Age	Address

APPLICANT 2 - RELATIVES (List Parents, Siblings and Significant Others):

Name	Related to Applicant 2	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? ☐ Yes ☐ No
Are you on probation or parole? ☐ Yes ☐ No

Have you or any member of your household been arrested or convicted of illegal substance use?
☐ 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 any of the questions above, please explain.

Date	Charge	Arresting Agency	Location	Disposition

EDUCATIONAL HISTORY: (Circle highest grade completed)

APPLICANT 1:

Grade School: 1 2 3 4 5 6 7 8

High School: 9 10 11 12

High School Name:_____

Graduation Date: _____

College/Trade School:

1 2 3 4 4+

Degree/Certificate Received (Year):

_____

Name of College/University Attended and Address:

_____

_____

Certificates Received (Year):

_____

_____

APPLICANT 2:

Grade School: 1 2 3 4 5 6 7 8

High School: 9 10 11 12

High School Name: _____

Graduation Date: _____

College/Trade School Training:

1 2 3 4 4+

Degree/Certificate Received (Year):

_____

Name of College/University Attended and Address:

_____

_____

Certificates Received (Year):

_____

_____

MILITARY STATUS:
Is Applicant 1 or Applicant 2 currently serving in the Armed Services? ☐ Yes ☐ No

Active: _____ Discharge: _____ Reserve: _____
If yes, please state branch: _____

FAMILY HEALTH HISTORY:

	APPLICANT 1:		APPLICANT 2:	
HAVE YOU EVER BEEN TREATED FOR:	**Yes**	**No**	**Yes**	**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:

_____
Condition Date
Treatment/Medication and Results
_____
_____
_____

Treatment/Medication and Results:
_____
_____
_____

APPLICANT 2:

_____
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. _____
2. Do you or any household member(s) smoke cigarettes/cigars? If so, how often. _____
   How do you prevent second hand smoke exposure? _____
   _____
3. Do you or any household member(s) chew tobacco? If so, how often. _____

MENTAL HEALTH HISTORY:

1. Are you or any household members currently receiving or have received mental health services?
   ☐ Yes ☐ No If so, check all that apply.
   ☐ Substance Abuse Counseling ☐ Anger Management ☐ Depression
   ☐ Marriage Counseling ☐ Domestic Violence Counseling ☐ Gambling Addiction
2. Have you or anyone in your household ever been hospitalized for psychiatric related issue (voluntarily/involuntarily)? If yes, please explain. _____
   _____
   _____
3. Have you or anyone in your household ever had a psychological evaluation? If yes, please explain.
   _____
   _____
4. Are you or anyone in your household currently taking or have taken any psychotropic medication for mental illness? If yes, please explain. _____
   _____
   _____
5. Have you or anyone in your household had suicidal ideation or attempts? If yes, please explain. ___
   _____
   _____

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 Net Pay
$_____ APPLICANT'S 2 Net Pay

Other Income (Child Support, Adoption Subsidy, and/or Other Source: SSI)
$_____ for _____
$_____ for _____
$_____ TOTAL MONTHLY HOUSEHOLD INCOME

Have you ever file for bankruptcy? Yes ☐ No
(If yes, complete the following):
Date Filed: _____
Date Closed: _____
Place Filed: _____
Results: _____

EXPENSES:

List Monthly Expenses:

$_____ Mortgage/Rent Payment
$_____ Utilities: Gas/Electric/Water/Propane
$_____ Phone
$_____ Food
$_____ Child Support
$_____ Alimony
$_____ Recreation/Entertainment
$_____ Charitable Contributions
$_____ Automobile Fuel
$_____ Vehicle Payment(s)
$_____ Vehicle Insurance
$_____ Revolving Charge Accounts
$_____ Life Insurance
$_____ Medical/Dental Insurance
$_____ Retirement/401K
$_____ Other:_____
$_____ TOTAL MONTHLY EXPENSES

ASSETS:

Family Residence: ☐ House ☐ Apartment ☐ Mobile Home ☐ Other
Description of Home: _____
_____
_____

Automobile(s): Make	Model	Year	Date of Final Payment
Boat/RV:			
Motorcycle/ATV			

Bank Accounts: Checking Account ☐ Yes ☐ No
Saving Account ☐ Yes ☐ No
Stocks/Bonds ☐ Yes ☐ No
Retirement Accounts (401K/Pension): ☐ Yes ☐ No

INSURANCE (Life, Auto, Home, Medical, and Dental Insurance Policy):

Name of Insured	Company	Type of Insurance	Amount	Beneficiary

V. LIFESTYLE:

RELIGIOUS AFFILIATION:

1. What is your religion?

COMMUNITY/NEIGHBORHOOD:

2. Tell us about your neighborhood. (Is your home located on or off an Indian Reservation?)

3. Tell us about community schools. (Is there public or private schools? How far are they located from the home? Where would your children be enrolled?)

4. Tell us about the local medical facilities.

5. Tell us about resources in your community, e.g., social services, law enforcement, fire department, child care or head start.

SOCIAL / CULTURAL ACTIVITIES:

6. What type of social/recreational activities does your family participate in? How often?

7. Does your family participate in any traditional/cultural events? If so, what type of events and how often?

8. Do you or any family members volunteer/participate in any community organization(s)? If yes, please list the organizations.

<u>If you are an Identified Relative, please skip this Section VI only & proceed to VII.</u>

VI. DESCRIPTION OF PROSPECTIVE CHILD:

NOTE: PLEASE BE AWARE THAT MOST OF OUR CHILDREN MAY NOT BE FULL NAVAJO.

1. Which gender do you want to adopt? ☐ Boy ☐ Girl ☐ No Preference

   ☐ Navajo ☐ Navajo/Hispanic ☐ Navajo/African American ☐ Navajo/Caucasian

   ☐ Navajo/Other Ethnic Group ☐ Other Tribe

2. Are you interested in adopting Special Needs/Disabled children? ☐ Yes ☐ No

3. Are you interested in adopting sibling groups? ☐ Yes ☐ No

4. Would you consider open adoption (contact with birth parent(s) or extended family members)? ☐ Yes ☐ No

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

6. Will you be willing and able to adopt a child with the following needs?

	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 (Please list 2 relatives & 1 non-relative, people not living in your household)

_____

Name Address (P.O., City, State, Zip) Phone# (Home/Work)

_____

Name Address (P.O., City, State, Zip) Phone# (Home/Work)

_____

Name Address (P.O., City, State, Zip) Phone# (Home/Work)

VIII. SIGNATURES (BOTH APPLICANTS):

Information contained herein is true and correct to the best of my/our knowledge. I/We hereby authorize the Division of Social Services – NCFS to use any and all information provided to complete my/our home study.

_____

Applicant's 1 Signature Date

_____

Applicant's 2 Signature Date

Revised: 03/30/17