Iowa Department of Health and Human Services

Application for Adoption

Leave Blank
Date Received:
Worker: Initial: Renewal:

I. Identifying Information

Applicant 1 Full Name:		
Applicant 2 Full Name:		
Street address:	City:	Zip:
County:	Telephone home/cell:	
Email address:		

NOTE: If applicants are not married and residing in the same household they must each complete a separate application for adoption.

II. List any Out-of-State Resident Address

Include applicant(s) and any other person aged 14 and over living in the home who have lived outside of Iowa in the last five years.

Name:	State:	County:

III. Children Available for Adoption

The Department of Health and Human Services seeks families who are able to parent children with special needs. Those children may have physical, mental, emotional/behavioral disabilities; may be a child aged five years or over; or may be a member of a sibling group of three or more. Applicants who wish to apply for children without special needs should be referred to licensed private child placing agencies.

IV. Type of Child I (We) Can Best Parent

Please indicate the type of child whose needs you feel you can best meet as a permanent member of your family.

Sex:	Age range:	Number of siblings who can be placed at one time:

Physical conditions:	Intellectual Disability:	Emotional/behavioral problems:
☐ Mild ☐ Severe ☐ Moderate ☐ At risk	☐ Mild ☐ Severe ☐ Moderate ☐ At risk	☐ Mild ☐ Severe ☐ Moderate ☐ At risk

Other comments regarding type of child who will best fit into your family:
If you are applying to adopt a specific child, Name of child: Name of assigned HHS worker and contact information if available

V. Factual Information

	Applicant 1				Applicant 2			
Birth date:								
Birthplace:								
U. S. citizenship/Legal Status: Description of Legal Status:	☐ Yes ☐ No				☐ Yes ☐ No			
Physical descriptions:	Height		Weight		Height		Weight	
	Eyes		Hair		Eyes		Hair	
Education: (last grade completed)								
Race or ethnic background:								
Religious Preference:								
Martial Status: Present:	Place:				Place:			
All Previous marriages:	Date: Place:				Date: Place:			
	Date: Place:				Date: Place:			
	Date: Place:				Date: Place:			
Current Occupation:								
Current Employer:								
Work telephone/email:								
Persons over age 18 residing in the home:	Full Name(s) & Birth date(s):				Relationship to Applicants:			

All Children currently residing in the home:	Full Name:	Birth date:	School & current grade:	Biological, foster or adopted

I have been convicted of a crime in another state. ☐ Yes ☐ No

If yes:
What state?
What was the crime?

I have a founded abuse report in another state. ☐ Yes ☐ No

If yes:
What state?
What was the abuse type?

VI. Acknowledgment

I understand it is my responsibility to notify the department of any change of address or if I am no longer interested in adoption. I also understand that neither this application nor the completion of the home study guarantees placement of a child.

I am aware that, subject to the provisions of Iowa Code Chapter 237, the Central Child Abuse Registry, the Department of Public Safety, and references in addition to those I have provided will be checked on all members of the household over the age of 14 for new applications and shall be checked for reapplications for all adult members of the household.

My signature below confirms I have provided factual and accurate information to the best of my knowledge in this document.

Date:	Date:
Applicant 1 Signature:	Applicant 2 Signature:
Applicant 1 Social Security Number (last four digits):	Applicant 2 Social Security Number (last four digits):

Policy Regarding Discrimination, Harassment, Affirmative Action, and Equal Employment Opportunity

It is the policy of the Iowa Department of Health Human Services (HHS) to provide equal treatment in employment and provision of services to applicants, employees, and clients without regard to race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief or veteran status.

If you feel HHS has discriminated against or harassed you, please send a letter detailing your complaint to: Iowa Department of Health and Human Services, Bureau of Policy Coordination, via email contactdhs@dhs.state.ia.us