ENROLLMENT CHECKLIST
POST ADOPTION SERVICES

Required Documents for Enrollment:

- ☐ Family Information Form
- ☐ Child Information Form
- ☐ Household Financial Information Form
- ☐ Adoption Decree (must list each child being enrolled)
- ☐ Parent Consent Form: one for each parent
- ☐ Child Consent Form: one for each enrolled child and signed by both parents
- ☐ Respite Release Form: signed by both parents

***completed forms can be returned via:**

- ☐ email: postadoption@centerstx.org
- ☐ fax: (800) 360-0145
- ☐ mail: Centers for Children and Families, attn: Post Adoption Services Program; 3701 Andrews Highway, Midland TX 79703

Post Adoption Services Intake
Family Information

Date: _____

Completed by: _____

Adoptive Parent(s): _____

Home Address: _____

County of Home Address: _____

Mailing Address, if different: _____

Email Address(es): _____

Phone Numbers (home/cell/work): _____

Preferred Means of Contact: _____

How did you learn about post adoption services?

_____

_____

What do you hope to gain by enrollment in the post adoption program?

_____

_____

Parent(s) In The Home

Name of Parent #1: _____

Relationship to Child: _____

Marital Status: _____

Gender: Male ☐ Female ☐

Race: White ☐ Black ☐ American Indian or Alaskan Native ☐ Asian ☐
Native Hawaiian or Other Pacific Islander ☐

Ethnicity: Hispanic/Latino ☐ Not Hispanic/Latino ☐

Religious Preference: _____

Name of Parent #2: _____

Relationship to Child: _____

Marital Status: _____

Gender: Male ☐ Female ☐

Race: White ☐ Black ☐ American Indian or Alaskan Native Asian ☐
Native Hawaiian or Other Pacific Islander ☐

Ethnicity: Hispanic/Latino ☐ Not Hispanic/Latino ☐

Religious Preference: _____

Household Information
List ALL children living in the home

Name	**D.O.B**	**Social Security No.**	**Gender**	**Race** White, Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander	**Ethnicity:** Hispanic/Latino or Non Hispanic/ Latino	**Status:** Birth, DFPS Adoption, Private Adoption, PCA, Relative or Other	**Age placed**

Others in the home (grandparents, adult children, etc.)

Name:_____

Age: _____

Relationship**:**_____

Significant Family Stressors:

Separation ☐ Divorce ☐ Recent Move ☐ Change in Schools ☐

Change in Financial Status ☐ Serious Illness ☐ Death ☐ Other ☐

Support System for Family

Marital Relationship	
Adult Children	
Extended Family	
Friends	
Neighbors	
Church	
School	
Support Group (in person or online)	

Child Information
(Complete one for each adopted child in the home)

Date:_____

Completed by:_____

Child's Full Legal Name:_____

Date of Birth: _____

Social Security Number:_____

Gender: Male ☐ Female ☐

Race: White ☐ Black ☐ American Indian or Alaskan Native ☐ Asian ☐
Native Hawaiian or Other Pacific Islander ☐

Ethnicity: Hispanic/Latino ☐ Not Hispanic/Latino ☐

Religious Preference:_____

Adoption Finalization Date: _____

Adoption Location (City/County/State):_____

Child's History
Child's Birth Name (if known):_____

County of DFPS Conservatorship:_____

Age entering DFPS system:_____

Trauma Abuse

Neglect ☐	Sexual Abuse ☐	Parental Substance Abuse ☐
Abandonment ☐	Physical Abuse ☐	Parental Mental Illness ☐
	Emotional Abuse ☐	Parental Criminal Behavior ☐

Number of placements prior to adoption:_____

Adoption Placement Agency:_____

Adoption Placement Worker _____

Biological Siblings:

Name/Age: _____

Current Placement: _____

Contact with Siblings? Yes ☐ No ☐

Type of Adoption:
Foster to Adopt ☐ Straight Adoption ☐ Relative Adoption ☐

Date of initial placement: _____

Date of adoption placement: _____

Relationship to child prior to adoption: _____

Number of placements prior to adoption: _____

Length of longest placement prior to adoption: _____

Number of prior adoptive placements: _____

Does child have contact with biological family? Yes ☐ No ☐

What does child understand about his/her adoption?

_____

_____

Child's Medical History:

Prenatal Alcohol/Drug Exposure? Yes ☐ No ☐ Unknown ☐

Serious Injuries/Surgeries/Hospitalizations: _____

Physical Disabilities/Limitations: _____

Allergies: _____

Child's Psychological Information

Therapy Participation

Dates	
Therapist Name	
Type of Therapy	
Additional info	

Evaluations

Dates	
Providers Name	
Type of Evaluation	
Diagnosis	
Additional info	

Other Mental Health Services

Dates	
Providers Name	
Type of Service	
Additional info	

Psychotropic Medication History

Medication Name	
Purpose	
Prescribers Name	
Dates	
Additional info	

Out of Home Placements

Start & End Date	
Name of Placement	
Location	
Reason for Placement	
Additional info	

Educational Information:

Current Grade:_____

School:_____

Public ☐ Private ☐ Charter ☐ Other ☐

District:_____

Services:_____

Regular Education ☐ Special Education ☐ Other ☐

Type of Disability:_____

504 Accommodations:_____

Gifted/Talented Program:_____

Household Financial Information

Adoptive Parents

	Name	
	Date of Birth	
	Social Security No.	
	Education Completed	
	Employer	
	Occupation	
	Monthly Income	
	Other Income	

Subsidy Information

Child's Name	**Subsidy Amount**	**County Providing Subsidy**	**Other Income (SS or SSI)**

Private Insurance

Policy Holder's Name:_____

Health Plan Carrier: _____

ID/Group Number: _____

Type of Coverage: Medical ☐ Dental ☐ Vision ☐

Additional Benefits/Value Added Services:

_____

_____

List members of the family **NOT** covered by the private insurance listed above:

_____

_____

_____

Medicaid information

Child's Name	**Medicaid Number**	**Type/Carrier** Traditional, Managed Care or Waiver Program

Additional Benefits/Value Added Services:

_____

_____

Parent Signature **Date**

CENTERS FOR CHILDREN AND FAMILIES
POST ADOPTION PROGRAM
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION (one for each person)

I, _____, hereby authorize **CENTERS FOR**
(Client or Legal Representative, **Parent**)
CHILDREN AND FAMILIES POST ADOPTION PROGRAM to release their records and/or information concerning ____myself_____to all service providers and
(Client)
authorize **all service providers** to release their records concerning the aforementioned client to **CENTERS FOR CHILDREN AND FAMILIES POST ADOPTION PROGRAM.**

This informed consent for the Release of Confidential Information shall cover all necessary information in order to facilitate treatment and obtain services.

I/We understand that this consent shall remain in force from the date signed until Post Adoption Program services are formally terminated.

I/WE also understand that I/WE may revoke this consent at any time by completing the second part of this form entitled Revocation of Consent or notifying Centers for Children and Families Post Adoption Program in writing of your Revocation of Consent.

_____	**SELF**	_____
Client or Legal Representative	Relationship to Client	Date
_____	_____	_____
Client or Legal Representative	Relationship to Client	Date

REVOCATION OF CONSENT

On this day, _____ of 20___ I/WE hereby revoke this consent for the release of information.

_____	_____	_____
Client or Legal Representative	Relationship to Client	Date
_____	_____	_____
Client or Legal Representative	Relationship to Client	Date

CENTERS FOR CHILDREN AND FAMILIES
POST ADOPTION PROGRAM
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION (one for each person)

I,_____, hereby authorize **CENTERS FOR**
(Client or Legal Representative, **Parent**)
CHILDREN AND FAMILIES POST ADOPTION PROGRAM to release their records

and/or information concerning ____myself_____to all service providers and
(Client)
authorize **all service providers** to release their records concerning the aforementioned client to

CENTERS FOR CHILDREN AND FAMILIES POST ADOPTION PROGRAM.

This informed consent for the Release of Confidential Information shall cover all necessary information in order to facilitate treatment and obtain services.

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	SELF	
Client or Legal Representative	Relationship to Client	Date
Client or Legal Representative	Relationship to Client	Date

REVOCATION OF CONSENT

On this day, _____ of 20___ I/WE hereby revoke this consent for the release of information.

Client or Legal Representative	Relationship to Client	Date
Client or Legal Representative	Relationship to Client	Date

CENTERS FOR CHILDREN AND FAMILIES
POST ADOPTION PROGRAM
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION (one for each child)

I/WE, _____, hereby authorize **CENTERS FOR**
(Client or Legal Representative, **Parents**)
CHILDREN AND FAMILIES POST ADOPTION PROGRAM to release their records and/or information concerning _____to all service providers and
(**CHILD'S NAME**)
authorize **all service providers** to release their records concerning the aforementioned client to **CENTERS FOR CHILDREN AND FAMILIES POST ADOPTION PROGRAM.**

This informed consent for the Release of Confidential Information shall cover all necessary information in order to facilitate treatment and obtain services.

I/We understand that this consent shall remain in force from the date signed until Post Adoption Program services are formally terminated.

I/WE also understand that I/WE may revoke this consent at any time by completing the second part of this form entitled Revocation of Consent or notifying Centers for Children and Families Post Adoption Program in writing of your Revocation of Consent.

_____	**Parent**	_____
Client or Legal Representative	Relationship to Client	Date
_____	**Parent**	_____
Client or Legal Representative	Relationship to Client	Date

REVOCATION OF CONSENT

On this day, _____ of 20___ I/WE hereby revoke this consent for the release of information.

_____	_____	_____
Client or Legal Representative	Relationship to Client	Date
_____	_____	_____
Client or Legal Representative	Relationship to Client	Date

RESPITE RELEASE FORM

Adoptive families using respite care are responsible for making arrangements for the care of their child/children with a caregiver of their choosing. Permission to transport the child/children, to care for the child/children, and to give medication and medical treatment to the child/children is given by the adoptive parents to the respite caregivers. Centers for Children and Families, their employees, and contract personnel may assist the families by providing the names of possible providers of respite care as a tool to help locate and provide services. This service is provided only as a suggestion and not as an assumption of responsibility for either party. Both parties – adoptive families and respite caregivers – agree to not hold Centers for Children and Families, their employees, or contract personnel responsible for any incidents, damages, or injuries that might occur while the respite care is being given.

This signed form should be returned and placed into your file at Centers for Children and Families before respite services are given or received.

_____ _____

Signature (Parent) Date

_____ _____

Signature (Parent) Date