Application

July 2011

Application Date ____________________

Prospective Mother's Name (Last, First)			Date of Birth
Prospective Father's Name (Last, First)			Date of Birth
Mother's Employer			Employer's Telephone Number
Father's Employer			Employer's Telephone Number
Home Address			
Town/City		State	Zip Code
Home Telephone Number	Daytime Telephone Number		E-mail Address

Child Characteristics

Gender Preference
- ☐Male ☐Female ☐Either

Age Preference
- ☐ Under 2 Yrs. ☐ 2-3 Yr.
- ☐ 4-6 Yr. ☐ 7-12 Yr. ☐ Over 12 Yr.

Sibling Group
- ☐ Yes ☐ No

Please check the program or programs you would prefer to adopt from. If you have selected more than one program, please note order of preference.

- ☐ Korea
- ☐ China
- ☐ Peru
- ☐ Thailand

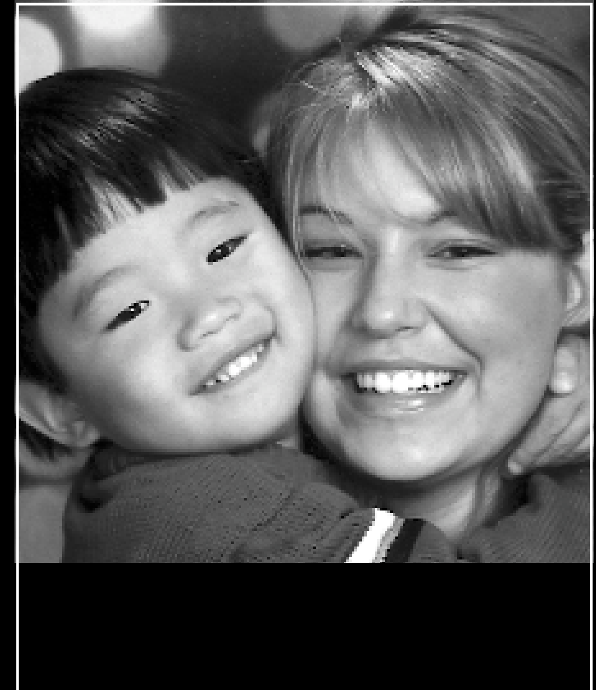
Networking Programs
- ☐ Colombia
- ☐ Russia

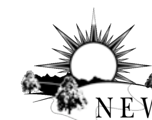
Cooperative Adoption
- ☐ Taiwan
- ☐ Bulgaria
- ☐ Other____________________

If you will consider a child with special needs, check all appropriate choices below.

Acceptable Disabilities

Physical	☐ Severe	☐ Moderate	☐ Mild
Mentally Challenged	☐ Severe	☐ Moderate	☐ Mild
Emotional/Behavioral	☐ Severe	☐ Moderate	☐ Mild
Learning/Attention Deficit Disorder	☐ Severe	☐ Moderate	☐ Mild
Malnutrition	☐ Severe	☐ Moderate	☐ Mild
Developmental Delay	☐ Severe	☐ Moderate	☐ Mild





Please write briefly about your motivation to adopt. Attach additional pages if needed.

Note: If your application is rejected or if your application has not been acted upon within six months of filing by the completion of the adoption study, you may request a state administration hearing. The hearing must be requested within 60 days after the date of rejection or failure to act.

Note: At such hearing you will have the right to be represented by counsel, or other representative, to produce witnesses and other evidence on your behalf. You will be permitted to request the issuance of subpoenas, to cross examine witnesses testifying against you, and to examine all of the evidence presented against you. If you request a hearing, address your request to: Officer of Temporary and Disability Assistance, PO Box 1930, Albany, New York 12243

Note: Social services Law 424-A requires the agency receiving this application to check with the New York State Register of Child Abuse and Maltreatment to determine whether an applicant is the subject of an indicated report of child abuse and maltreatment.

To start the adoption process, fill out the application and return it with a check for $50.00 (Application Fee) to New Beginnings.

If you live in Florida, return the application to 1902 Ibarra Place, The Village, Florida 33159.
All other applications should be sent to 87 Mineola Boulevard, Mineola, New York 11501

Signature of Prospective Mother ______________________

Date ______________________

Signature of Prospective Father ______________________

Date ______________________

Note: Applicant should retain copy.

New Beginnings is an Equal Opportunity employer. New Beginnings accepts applications to adopt without regard to age, sex, race, color, national origin, ancestry religion creed, disability marital status and employment status, or limited english proficiency. Complaints of discrimination may be filed with the office for civil rights, US Department of Health and Human Services; Bureau of Civil Rights compliance, Department of Public Welfare; and/or your state's Human Relations Commission

For Official Use Only

Family Profile Sent______________________

Distributed at______________________

Program Selected______________________

Application Approved______________________