17th Judicial Circuit Court for the County of Kent

NON-RELATIVE GUARDIAN ADOPTION CHECKLIST

All adoption forms must be completed and signed legibly either print or type, with complete names (first, middle and last) as listed on the birth certificate(s). Make sure filings are complete. The checklist is intended to outline most of the documents needed. However, the court may require additional materials. Court personnel are unable to provide legal advice. To expedite the filing process, please organize the items below according to this checklist.

All filings are to be mailed or delivered to: (616) 632-5107 or (616) 632-5108
Kent County Adoption Department
180 Ottawa Ave NW, Suite 3500, Grand Rapids, MI 49503

GENERAL CONSIDERATIONS:

- The adoption department cannot process adoptions for petitioner(s) who are not residents of Kent County.
- Certified document(s) required for filing will not be returned to the petitioner(s).
- All adoption court forms recommended for use by the Michigan Supreme Court are available on-line at the State Court Administrative Office to complete and print. (website => courts.mi.gov)
- This checklist provides the corresponding recommended court form number(s) in parentheses.
- The failure to timely submit documentation may result in a dismissal of the case for lack of progress.

INITIAL DOCUMENTS REQUIRED:

PETITION(S) & SUBSEQUENT FILING(S)

1. ☐ Petition for adoption (PCA 301) (one per child, any name change should be reflected on Petition), Data Entry Sheet, and Cover Letter detailing specifics and/or any special instructions for the filing.

LEGAL PARENT(S)

(COURT SEAL NEEDED FOR ORDERS OUTSIDE OF KENT COUNTY)

2. ☐ If any court order(s) terminating the parental rights of the legal parent(s) exist, then provide such.
3. ☐ If any parent(s) is/are deceased, then provide a certified copy of the death certificate(s).
4. ☐ If biological parents are unwilling to consent to the adoption, an attorney is required to file a Guardian Initiated Termination Petition under the Juvenile Code MCL 712A.19b(3)(a-m). It is recommended this be completed prior to filing the adoption.

CENTRAL REGISTRY CHECK

5. ☐ A completed (Section II Only) Licensing Record Clearance Request Form (CWL-1936) as to each petitioner.

   Note: clearances for female petitioner(s) must be completed on current and any previous maiden name

6. ☐ A completed (Section II Only) Licensing Record Clearance Request Form (CWL-1936) as to all adults residing in the home.

ADOPTEE

7. ☐ Original birth certificate of adoptee. Note: If adoptee was not born in the United States, then residency documentation is required.
8. ☐ Medical report current within 1 year of filing.
9. ☐ If school age, most recent report card.

ACCOUNTING

10. ☐ Verified 7-day accounting itemized on the form with receipt(s) attached: (one per child)
    ☐ Petitioner(s) (PCA 347) ☐ Attorney(s) (PCA 346), when applicable

ADOPTIVE PARENT(S)

11. ☐ Adoptive history report completed. (Kent County Adoption Department form).
12. ☐ Copy of birth certificates of each petitioner.
13. ☐ Copies each petitioner's driver's license or state identification.
14. ☐ Copy of current marriage certificate of petitioners, when applicable.
15. ☐ Copies of all marriage certificate(s) of each petitioner, when applicable.
16. ☐ Copies of all divorce decree(s) of each petitioner, when applicable.
17. ☐ Copy of death certificate of a previous spouse, when applicable (Not in lieu of a divorce decree).
18. ☐ Medical report for each petitioner current within 1 year of filing (DHS-3190).
19. ☐ Reference letters – submit 3 from non-relative persons who have known you several years (Kent County Adoption Department form).
20. ☐ Copy of court order of legal name change, when applicable.
21. ☐ Copy of naturalization papers, when applicable.
22. ☐ Copy of guardianship order, when applicable.

GUARDIANSHIP

23. ☐ Order of appointment of full guardianship of the child(ren). (Must be current)

FINALIZATION DOCUMENTS REQUIRED:

24. ☐ Verified (Supplemental/21-day) accounting itemized on the form with receipt(s) attached: (one per child) ☐ Petitioner(s) (PCA 347a) ☐ Attorney(s) (PCA 346), when applicable
25. ☐ Report to establish a new MI birth certificate (DCH-0854) (1 per child)

COURT FEES: (All fees are non-refundable)

INITIAL FILING FEES

☐ $185 filing fee must accompany each petition for adoption, & a $100 Home Assessment Fee. (One check) This fee may be paid by check or money order payable to "17th Judicial Circuit Court."

☐ $50 fee to establish a new Michigan birth certificate and $16 for each additional copy – check or money order (no cash) made payable to "State of Michigan" is due at the time of requesting finalization. Upon finalization of the adoption, if requested, a new birth certificate will be created, and the original birth record will be sealed.

NOTE: Birth certificates are amended in the adoptee's state of birth. Fees and required documentation vary from state to state. If the adoptee was born in a state outside of Michigan, then it is the responsibility of Petitioner(s) to submit to our department the appropriate fees and document(s) required by that state's respective vital records department to create a new birth record resulting from an adoption.

ADDITIONAL FEES:

☐ Each subsequent petition, motion, etc. $20

Any questions concerning these procedures, please contact your attorney, or the Kent County Adoption Department at 616-632-5107, 616-632-5108

08/01/2022 HH

17th JUDICIAL CIRCUIT COURT, FAMILY DIVISION ADOPTION DATA ENTRY SHEET

THIS FORM MUST BE FILLED IN LEGIBLY, COMPLETELY AND ACCURATELY

ADOPTEE INFORMATION						
Birth Name or Current Legal	Last Name	First	Middle			
Adopted (Name to be)	Last Name	First	Middle			
Sex □ Male □ Female	Birthplace (City, County and State)	Date of Birth				
Race □ White □ African American □ Hispanic □ Native American □ Asian □ Other or Bi-Racial (please specify)						
Adoptee's School District:						

ADOPTIVE PETITIONER/S INFORMATION						
Petitioner #1:	Last Name / Maiden/Original	First	Middle	DOB	SS#	Race
Petitioner #2 Parent or Custodial Parent	Last Name / Maiden/Original	First	Middle	DOB	SS#	Race
Email for adoptive family						
Address (No. and Street)		County	Marriage Date			
City	State	Zip	Phone			

ATTORNEY FOR PETITIONER/s IF APPLICABLE			
Attorney Name	First	Last	Bar No: P-

(PLEASE NOTE: NOTICE MUST BE SENT TO BIOLOGICAL PARENTS) – (NOT APPLICABLE FOR DELAYED REGISTRATION OF FOREIGN BIRTH)

BIRTH PARENT INFORMATION (NOT REQUIRED FOR DELAYED REGISTRATION OF FOREIGN BIRTH)						
Birth Mother	Last Name / Maiden/Original	First	Middle		DOB	Race
Address (No. and Street)		City	State	Zip	Phone: / Email:	
Birth Father	Last Name	First	Middle		DOB	Race
Address (No. and Street)		City	State	Zip	Phone: / Email:	
Will Non-Custodial Parent be willing to consent to this adoption? ☐YES or ☐NO						
Will an interpreter be Needed for any parties? ☐YES or ☐NO If yes, What language? _____						

Approved, SCAO JIS CODE: APF

STATE OF MICHIGAN JUDICIAL CIRCUIT - FAMILY DIVISION COUNTY	PETITION FOR ADOPTION ☐ Related Within 5th Degree ☐ Other (Excluding Direct Adoption)	FILE NO.

Note: For stepparent adoptions, use form PCA 301b.

In the matter of _____, adoptee
Full name of child

The petitioners are:

Name	Relationship to Adoptee	Address, City, State, Zip	Date (MM/DD/YYYY) and Place of Birth
☐ Adopting parent Maiden:			
☐ Adopting parent Maiden:			

Each adopting petitioner states:

☐ 1. An action within the jurisdiction of the family division of circuit court involving the family or family members of the minor has been previously filed in _____ Court, Case Number _____, was assigned to Judge _____, and ☐ remains ☐ is no longer pending.

2. I desire to adopt: _____ _____
Full name of child (type or print) Birth date and time

_____
City, county, and state of birth

_____
Current residential address (if known)

3. The adoptee will be my heir at law.

4. The adoptee's name will ☐ not be changed. ☐ be changed to _____.
First Middle Last

5. The adoptee's property is _____.

6. ☐ a. The adoptee's parents are

_____ _____
Father's name (type or print) Birth date Mother's name and maiden name (type or print) Birth date

_____ _____
Address Address

_____ _____
City, state, zip City, state, zip

☐ b. The rights of the parents have been terminated by a court of competent jurisdiction and parental rights are vested in

_____.
Name and address of court or agency

(See additional pages)

Do not write below this line - For court use only

☐ 7. The adoptee's court-appointed guardian and/or conservator is/are (attach copy[ies] of letters of authority)

_____
Name(s) and address(es)

_____.

☐ 8. The adoptee has been living with the petitioners in their home for _____ months before filing this petition.

☐ 9. I have been unable to obtain the required consent to adopt the child from the court, Michigan Department Health and Human Services or child-placing agency having permanent custody, or from the persons to whom the child was released. A motion alleging that the decision to withhold consent was arbitrary and capricious is attached.

☐ 10. I am married but my spouse is not joining me in this position because: (Attach separate sheet as needed.) .

☐ 11. The adoptee is an Indian child as defined in MCR 3.002(12). The identity of the tribe is

_____.
Name of tribe, if known

I REQUEST:

12. Termination of all existing parental rights inconsistent with the order of adoption, entry of an order approving placement of the child with me, and entry of an order of adoption with the adoptee's name recorded as stated in item 4.

☐ 13. The adoption to be completed immediately because _____

_____.

☐ 14. The court to waive the required investigation because the adoptee has been placed in foster care with me for at least 12 months and a foster family study was completed or updated within the last 12 months.

I declare that the statements above are true to the best of my information, knowledge, and belief.

Attorney signature	Date
Attorney name (type or print) P- Bar no.	Signature of petitioner
Address	Signature of petitioner
City, state, zip Telephone no.	Petitioner telephone no.

Agency Contact Information:

Name of agency representative (type or print)	Address
Agency name	City, state, zip
Telephone no.	E-mail

IT IS ORDERED:

☐ 15. _____ is directed to fully investigate and
Court agent or employee, child-placing agency, or Michigan Department of Health and Human Services
and report its findings in writing to this court, within 3 months of this order, in accordance with the provisions of MCL 710.46.

☐ 16. The full investigation is waived. The petitioner(s) shall file a copy of the most recent foster family study as updated and supplemented.

☐ 17. The petitioner(s) shall give notice of this petition to the persons prescribed in MCR 3.800(B) in accordance with MCR 3.802(A)(3) and MCR 3.807(B), if applicable (use form PCA 352).

_____ _____

Date Judge Bar no.

Approved, SCAO

JIS CODE: PCS and MiCOURT - PVA
TCS - PVA7

STATE OF MICHIGAN JUDICIAL CIRCUIT - FAMILY DIVISION COUNTY	PETITIONER'S VERIFIED ACCOUNTING	FILE NO.

In the matter of _____ DOB: _____, adoptee
Full name of child

I filed a petition to adopt the adoptee. This accounting is a complete itemization of payments/disbursements of money or anything of value made or agreed to be made by me or on my behalf in connection with this adoption as of this date. Form PCA 347a will be submitted to report any additional payments/disbursements of money or anything of value made or agreed to be made by me or on my behalf in connection with this adoption.

EXPENSES	TOTAL
1. Court Filing Fee Petition for Adoption $ 175.00 Order of Adoption $ 10.00 Motion for Early Confirmation $ Other petitions, motions, orders $	$ 185.00
2. Agency/Michigan Department of Health and Human Services Charges (itemized on other side of this form)	$ 100.00
3. Attorney Fees (itemized on other side of this form)	$
4. Travel Expenses (itemized on other side of this form)	$
5. Medical, Hospital, Nursing, or Pharmaceutical Expenses (itemized on other side of this form)	$
6. Counseling Services (itemized on other side of this form)	$
7. Living Expenses (itemized on other side of this form)	$
8. Information Gathering Expenses (itemized on other side of this form)	$
9. Other (itemized on other side of this form	$
I REQUEST that the court approve these payments and disbursements. **TOTAL**	$ 285.00

I declare that this accounting and the attachments have been examined by me and that the contents are true to the best of my information, knowledge, and belief.

_____
Date

Signature of petitioner	Signature of petitioner
Name (print or type)	Name (print or type)
Address	Address
City, state, zip Telephone no.	City, state, zip Telephone no.

NOTE: This accounting must be filed at least 7 days before formal placement for adoption.

Do not write below this line - For court use only

ITEMIZED ACCOUNTING OF PAYMENTS/DISBURSEMENTS

Instructions: The following are types of expenses that must be itemized. Each type of expense is explained. For each type, identify the type by number, list each expense in that type separately, total the amounts, and place the total under the same type number on the front of this form. If the space provided below is not adequate, make copies before writing any information on this form. Write in the date for each payment made, the amount of that payment, who that payment was made to, and the purpose of the payment for the following types: **You must attach a receipt for each payment/disbursement.**

Type 2. Agency Charges - fees and expenses charged by and to be paid to the agency.
Type 3. Attorney Fees - fees and expenses charged by and to be paid to the attorney.
Type 4. Travel Expenses - expenses associated with travel that are necessary to the adoption.
Type 5. Medical Expenses - expenses connected with birth of the child or illness of the child not covered by birth parent's health care benefits or Medicaid.
Type 6. Counseling Expenses - expenses for counseling related to the adoption for the parent, guardian, or adoptee.
Type 7. Living Expenses - expenses of the mother before birth of the child and for no more than six weeks after the birth.
Type 8. Information Gathering Expenses - expenses for getting required information about the adoptee and the adoptee's biological family.
Type 9. Other – includes copy costs, process server fees, etc.

TYPE NO.	DATE	AMOUNT	NAME AND ADDRESS OF RECIPIENT	PURPOSE
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		$		
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ADOPTIVE HISTORY REPORT

KENT COUNTY ADOPTION DEPARTMENT

This form is to be completed and signed legibly in black ink or typed, with complete names (FIRST, MIDDLE and LAST) as listed on the respective birth certificates. If a certain area does not apply, write or type N/A.

ADOPTIVE PARENT(S) INFORMATION:

	Petitioner #1	Petitioner #2 or Custodial Parent
Name (First, Middle, Last)		
Maiden Name		
Relationship to Adoptee		
Length of Petitioner's Relationship Dating & marriage, also describe your marriage and how you handle conflict.		
Driver's License Number		
Address, City State, Zip		
Telephone Number		
Email		
Race/Nationality		
Military History		
Education Level		
Name of High School, year graduated		
Name of College, year graduated		
Employer		
Occupation		
Length of Employment		
Income (Monthly)		
Hobbies/Interests		
Religious Preferences		
If Married – License #		
Previous Marriage (Date & Place)		

Divorce (Date & Place)		
Support Order/Amount		
Previous Marriage (Date & Place)		
Divorce (Date & Place)		
Support Order/Amount		

ADOPTIVE PARENT(S) INFORMATION CONTINUED:

Custodial Parent has ☐ Joint or ☐ Sole – Physical Custody (and) ☐ Joint or ☐ Sole – Legal Custody

Have petitioning parent(s) been convicted of a criminal proceeding, imprisoned, and placed on probation and/or parole (including DUI)? ☐ No ☐ Yes; If yes, described in detail, the date, place, nature of offense and outcome (If need more space, please attach addendum): _____

_____

_____

_____

_____

Do you owe restitution & or court fee's? ☐ No ☐ Yes If Yes, balance $_____

Has any petitioning parent had any contact with Children's Protective Services? ☐ No ☐ Yes

Name of CPS Worker _____ Phone: _____

If yes, describe in detail, the CPS contact including the parties involved, the nature of the petitioner's involvement, specifics of the circumstances, and outcome: (If more space is needed, please attach an addendum)

_____

_____

_____

Has any member of the household ever been listed on the Central Registry ☐ No ☐ Yes If yes, describe in detail, the Central Registry contact including the context of the person(s) named on the registry, the specifics of the circumstances that led to being placed on the Central Registry and if the person's name was taken off (expunged):

(If more space is needed, please attach an addendum)

_____

_____

_____

_____

Do you ☐ Own ☐ Rent your home? Is there ample room for household members? Please describe:

_____

_____

_____

Are there any water hazards near the premises? ☐ No ☐ Yes. If yes, please describe how the petitioner(s) safeguard child(ren) around them (Water hazards include pools, ponds, etc.): _____

Are there any weapons in the home? ☐ No ☐ Yes. If yes, please describe the type and how they are stored:

_____

_____

Does any Petitioner have a diagnosed medical or mental health condition by a licensed professional that may impact the ability to care for a child? ☐ No ☐ Yes; If yes, describe your treatment plan including medications prescribed and your ability to meet the needs of the child(ren) _____

_____

_____

_____

_____

_____

_____

_____

Please describe your family's strengths, traditions, & activities: _____

_____

_____

_____

HOUSEHOLD MEMBERS INFORMATION: **(Including adult children not residing in the home, such as attending college, armed forces, etc.):**

Name ***(First, Middle, Last)*** _____

Relationship to Adoptee _____

Birth Date _____

Driver's License Number _____

Name ***(First, Middle, Last)*** _____

Relationship to Adoptee _____

Birth Date _____

Driver's License Number _____

Name ***(First, Middle, Last)*** _____

Relationship to Adoptee _____

Birth Date _____

Driver's License Number _____

Name ***(First, Middle, Last)*** _____

Relationship to Adoptee _____

Birth Date _____

Driver's License Number _____

BIRTH PARENTS INFORMATION:

	BIRTH MOTHER	BIRTH FATHER
NAME *(First Middle, Last)*		
DOB		
Address		
Nationality/Race		
Native American Indian Heritage	☐ Yes ☐ No	☐ Yes ☐ No
If Yes, the name of the Tribe/Band		
Name and Relationship of relative w/Indian Heritage		
Place of Birth		
Religion		
Eye Color		
Hair Color		
Complexion		
Education		
Occupation		
Allergies		
If deceased, date & cause of death		
Medical History and any diagnosis		
Armed Forces/Branch		
Hobbies/Interests		

Are birth parents aware of the Central Adoption Registry whereby a birth parent may submit a written Consent or Denial as to the Release of Identifying Information about oneself to an Adult Adoptee that may at a later date seek out such information about his/her birth parents:

Birth Mother ☐ Yes ☐ No ☐ Unknown **Birth Father ☐ Yes ☐ No ☐ Unknown**

ADOPTEE INFORMATION:

Current Legal Name: (*First, Middle, Last)* _____

Address: _____

DOB: _____ Time of Birth: _____am/pm Sex: ☐ Female ☐ Male

Hospital of Birth: _____

Place of Birth: *(county, city, state, country)* _____

Gestational Age: _____ Weeks Birth Weight: _____ Pounds _____ Ounces Length: _____Inches

Neonatal Drug Exposure: _____ Prenatal Care: ☐ Yes ☐ No

Medication Used in Delivery: _____ Type of Delivery ☐ Natural ☐ Cesarean

Length of Stay in the Hospital: _____

Pregnancy/delivery complications: _____

_____

_____

Was the birth mother married to someone else (not the biological father) at the time of conception?

☐ Yes ☐ No If yes, name & contact information of spouse: _____

_____

Adoptee's overall medical health: _____

_____

_____

Adoptees performance in school, educational testing results & special education needs, hobbies/special interests, highest grade completed/college degree, occupation: _____

_____

_____

_____

_____

How does the child feel about being adopted? Does the child know they are being adopted? _____

_____

_____

_____

_____

SIBLINGS OF ADOPTEE: (No need to name siblings previously listed under household members)

Name: *(First, Middle, Last)* _____ DOB _____
Gender: ☐ Male ☐ Female Step: ☐ Yes ☐ No Hobbies/Special Interests: _____

Name: *(First, Middle, Last)* _____ DOB _____
Gender: ☐ Male ☐ Female Step: ☐ Yes ☐ No Hobbies/Special Interests: _____

Name: *(First, Middle, Last)* _____ DOB _____
Gender: ☐ Male ☐ Female Step: ☐ Yes ☐ No Hobbies/Special Interests: _____

Name: *(First, Middle, Last)* _____ DOB _____
Gender: ☐ Male ☐ Female Step: ☐ Yes ☐ No Hobbies/Special Interests: _____

ADOPTEE'S HEALTH & GENETIC MATERNAL HISTORY:

	Maternal Grandmother	**Maternal Grandfather**
NAME *(First Middle, Last)*		
DOB		
Address		
Nationality/Race		
Native American Indian Heritage	☐ Yes ☐ No	☐ Yes ☐ No
If Yes, the name of the Tribe/Band		
Name and Relationship of relative w/Indian Heritage		
Place of Birth		
Religion		
Eye Color		
Hair Color		
Complexion		
Education		
Occupation		
Allergies		
If deceased, date & cause of death		
Medical History and any diagnosis		
Armed Forces/Branch		
Hobbies/Interests		

ADOPTEE'S HEALTH & GENETIC PATERNAL HISTORY:

	Paternal Grandmother	Paternal Grandfather
NAME *(First Middle, Last)*		
DOB		
Address		
Nationality/Race		
Native American Indian Heritage	☐ Yes ☐ No	☐ Yes ☐ No
If Yes, the name of the Tribe/Band		
Name and Relationship of relative w/Indian Heritage		
Place of Birth		
Religion		
Eye Color		
Hair Color		
Complexion		
Education		
Occupation		
Allergies		
If deceased, date & cause of death		
Medical History and any diagnosis		
Armed Forces/Branch		
Hobbies/Interests		

Does the adoptee have any contact with members of his/her biological family? If so, with whom:

_____

_____

Please indicate if there is any information you do not want discussed in front of your child(ren) at the home visit:

_____

_____

REPRESENTED BY AN ATTORNEY:

Name of Attorney: _____ Bar No: ___P-_____

Address: _____

Email: _____

Phone: _____ Fax: _____

THIS ADOPTION QUESTIONAIRE HAS BEEN EXAMINED BY ME AND THE CONTENTS ARE TRUE TO THE BEST OF MY INFORMATION, KNOWLEDGE, AND BELIEF. ANY FALSIFICATION OF INFORMATION MAY RESULT IN THE DENIAL OF THE ADOPTION.

Petitioner 1/Adoptive Parent Signature: _____ Date:_____

Petitioner 2/Adoptive Parent Signature: _____ Date:_____

Attorney Signature (when applicable): _____ Date: _____

***IF THE PERSON THAT IS BEING ADOPTED IS AN ADULT – PLEASE ATTACH A SEPARATE TYPED/ WRITTEN STATEMENT INDICATING THE REASON FOR THE ADOPTION.**

RELATIVES OF PETITIONER 1

NAME	ADDRESS	ETHNICITY	OCCUPATION	AGE	IF DEAD, AGE/CAUSE	PHYSICAL/MENTAL ILLNESSES
MOTHER						
FATHER						
SIBLINGS						

RELATIVES OF PETITIONER 2

NAME	ADDRESS	ETHNICITY	OCCUPATION	AGE	IF DEAD, AGE/CAUSE	PHYSICAL/MENTAL ILLNESSES
MOTHER						
FATHER						
SIBLINGS						

LICENSING RECORD CLEARANCE REQUEST
FOSTER HOME/ADOPTIVE HOME
ONLY FOR HOUSEHOLD MEMBER

Michigan Department of Health and Human Services
Division of Child Welfare Licensing

SECTION I: REQUESTOR INFORMATION (Must be completed by licensing consultant/worker)

Agency Name and Address:

ATTN: LADAWN VENEMA
ADOPTION-F21, BETHANY CHRISTIAN SERVICES
PO BOX 294, 901 EASTERN AVE NE
GRAND RAPIDS MI 49501-0294

CPA License Number
CB410200976

***Adult Household Members Are Not Fingerprinted**

Fold Mark

Directions for Completing Form:	**NO R1-030 Needed**
• Please read the accompanying instructions before completing this form. • Please type or print CLEARLY so that the information provided can be read. • Mail completed form to DCWL Central Office or address noted in box below.	☐ Adoption AHHM: ☐ AWA or ☐ AWP ☐ Foster Home Renewal ☐ Foster Home Adding/18 years old + ☐ Foster Home Initial MiSACWIS Person ID: _____

Worker's Information

Worker's Name	Email	Telephone Number
LADAWN VENEMA	**IVENEMA@BETHANY.ORG**	**616 224-7565**

Applicant Information

Licensee/Applicant Name Full (Last, First)	County	DCWL Licensee Number (If assigned)
Date of Birth		

☐ Specific relationship to licensee: _____

SECTION II: CLEARANCE INFORMATION (To be completed by household member or other person to be cleared).

Name (Last, First, Middle, Jr., II, etc.)	Gender	Birth Date	Social Security #

Marital Status ☐ SGL ☐ MAR ☐ DIV ☐ WID	Also Known as [Aliases, maiden name, previous married name(s)]
Address (Street Number and Name)	Michigan Driver's License or State ID Number

City	County	State	Zip Code	Phone Number	Race	Height	Weight

Have you always lived in Michigan?
☐ No ☐ Yes

If you have lived outside of Michigan in the past 5 years, please list the states/countries where you have lived:

Have you ever:
Been convicted of a crime, felony or misdemeanor?
☐ No ☐ Yes (If yes, explain) _____

Been substantiated for abuse or neglect of children or adults?
☐ No ☐ Yes (If yes, explain) _____

Type, Location, and Date of Conviction(s) or Substantiations: (for additional space attach separate sheet)

My signature certifies that I have reviewed the information on the back of this form.

Signature of Person or Guardian to be Cleared	Date

SECTION III: CENTRAL RECORDS CLEARANCE (DCWL Use Only)

Address on Michigan Public Sex Offender Registry? ☐ No ☐ Yes	Initials/Clearance Date
Secretary of State Discrepancy? ☐ No ☐ Yes	Initials/Clearance Date
Individual on Central Registry? ☐ No ☐ Yes	Initials/Clearance Date
Individual with MiSACWIS/CPS History? ☐ No ☐ Yes	Initials/Clearance Date
Previous Registration/License ☐ No ☐ Active ☐ Closed	Initials/Clearance Date
Previous Registration/License Number:	Adverse Action? ☐ Yes

SECTION IV: CONVICTION CLEARANCE

(DCWL Use Only)

LICENSING RECORD CLEARANCE REQUEST INSTRUCTIONS

The purpose of this form is to:

1. Produce a Department of State Police check regarding the possible existence of a conviction record.
2. Produce a Michigan Department of Health and Human Services Central Registry File check regarding the possible existence of a substantiated child abuse or neglect record.
3. Produce a Division of Child Welfare Licensing (DCWL) files check against current or previous licensee status of the applicant in any county of the state.

The existence of a conviction record does not necessarily disqualify an applicant for licensure. However, it does provide DCWL and the child placing agency with information, which will be carefully evaluated by licensing staff.

A failure on the part of an applicant to provide DCWL with accurate and truthful information and the authorization requested on this form may be sufficient cause to deny issuance of a license or certificate of registration.

- I am aware that Michigan Department of State Police Records will be checked for information regarding criminal convictions under authority of the Child Care Organizations Act 116 of 1973.
- I am aware that the Michigan Department of Health and Human Services Central Registry will be checked for information concerning substantiated child abuse and neglect.
- I certify that the information I have given on the form is, to the best of my ability, true and correct.
- The Department may perform this check at any time while I am household member.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.
Authority: 1973 PA 116 Completion: Required Consequence: Registration/Licensure may be denied or revoked.

LICENSING RECORD CLEARANCE REQUEST
FOSTER HOME/ADOPTIVE HOME
ONLY FOR HOUSEHOLD MEMBER

Michigan Department of Health and Human Services
Division of Child Welfare Licensing

SECTION I: REQUESTOR INFORMATION (Must be completed by licensing consultant/worker)

Agency Name and Address:

ATTN: LADAWN VENEMA
ADOPTION-F21, BETHANY CHRISTIAN SERVICES
PO BOX 294, 901 EASTERN AVE NE
GRAND RAPIDS MI 49501-0294

CPA License Number
CB410200976

***Adult Household Members Are Not Fingerprinted**

Fold Mark

Directions for Completing Form:	**NO R1-030 Needed**
• Please read the accompanying instructions before completing this form. • Please type or print CLEARLY so that the information provided can be read. • Mail completed form to DCWL Central Office or address noted in box below.	☐ Adoption AHHM: ☐ AWA or ☐ AWP ☐ Foster Home Renewal ☐ Foster Home Adding/18 years old + ☐ Foster Home Initial MiSACWIS Person ID: _____

Worker's Information

Worker's Name	Email	Telephone Number
LADAWN VENEMA	**IVENEMA@BETHANY.ORG**	**616 224-7565**

Applicant Information

Licensee/Applicant Name Full (Last, First)	County	DCWL Licensee Number (If assigned)
Date of Birth		

☐ Specific relationship to licensee: _____

SECTION II: CLEARANCE INFORMATION (To be completed by household member or other person to be cleared).

Name (Last, First, Middle, Jr., II, etc.)	Gender	Birth Date	Social Security #

Marital Status ☐ SGL ☐ MAR ☐ DIV ☐ WID	Also Known as [Aliases, maiden name, previous married name(s)]
Address (Street Number and Name)	Michigan Driver's License or State ID Number

City	County	State	Zip Code	Phone Number	Race	Height	Weight

Have you always lived in Michigan?
☐ No ☐ Yes

If you have lived outside of Michigan in the past 5 years, please list the states/countries where you have lived:

Have you ever:
Been convicted of a crime, felony or misdemeanor?
☐ No ☐ Yes (If yes, explain) _____

Been substantiated for abuse or neglect of children or adults?
☐ No ☐ Yes (If yes, explain) _____

Type, Location, and Date of Conviction(s) or Substantiations: (for additional space attach separate sheet)

My signature certifies that I have reviewed the information on the back of this form.

Signature of Person or Guardian to be Cleared	Date

SECTION III: CENTRAL RECORDS CLEARANCE (DCWL Use Only)

Address on Michigan Public Sex Offender Registry? ☐ No ☐ Yes	Initials/Clearance Date
Secretary of State Discrepancy? ☐ No ☐ Yes	Initials/Clearance Date
Individual on Central Registry? ☐ No ☐ Yes	Initials/Clearance Date
Individual with MiSACWIS/CPS History? ☐ No ☐ Yes	Initials/Clearance Date
Previous Registration/License ☐ No ☐ Active ☐ Closed	Initials/Clearance Date
Previous Registration/License Number:	Adverse Action? ☐ Yes

SECTION IV: CONVICTION CLEARANCE

(DCWL Use Only)

LICENSING RECORD CLEARANCE REQUEST INSTRUCTIONS

The purpose of this form is to:

1. Produce a Department of State Police check regarding the possible existence of a conviction record.
2. Produce a Michigan Department of Health and Human Services Central Registry File check regarding the possible existence of a substantiated child abuse or neglect record.
3. Produce a Division of Child Welfare Licensing (DCWL) files check against current or previous licensee status of the applicant in any county of the state.

The existence of a conviction record does not necessarily disqualify an applicant for licensure. However, it does provide DCWL and the child placing agency with information, which will be carefully evaluated by licensing staff.

A failure on the part of an applicant to provide DCWL with accurate and truthful information and the authorization requested on this form may be sufficient cause to deny issuance of a license or certificate of registration.

- I am aware that Michigan Department of State Police Records will be checked for information regarding criminal convictions under authority of the Child Care Organizations Act 116 of 1973.
- I am aware that the Michigan Department of Health and Human Services Central Registry will be checked for information concerning substantiated child abuse and neglect.
- I certify that the information I have given on the form is, to the best of my ability, true and correct.
- The Department may perform this check at any time while I am household member.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.
Authority: 1973 PA 116 Completion: Required Consequence: Registration/Licensure may be denied or revoked.

MEDICAL STATEMENT FOR ADOPTION

To be Completed for Adoptive Child
Kent County Circuit Court Adoption Department

Patient Information (to be completed by patient or responsible adult)

Name	Relationship Adoptee	Date of Birth
Address (Street, City, State, Zip)		
Are you currently taking any medication? If yes, please list medications and reason for use		

Have you ever been treated for any of the following? (check all that apply)

☐ Heart Disease	☐ Kidney Disease	Cancer	Diabetes
☐ Emphysema	☐ Epilepsy	Tuberculosis	
☐ Alcohol Abuse	☐ Substance Abuse	Mental Health Issues	
☐ Current Communicable Disease		Other Serious or chronic illness	

If any are checked, please explain _____

If you <u>have</u> checked any of the above, please have page 2 of this form completed by your licensed physician, physician's assistant, or nurse practitioner.

If you <u>have not</u> checked any of the above, please have your licensed physician, physician's assistant or nurse practitioner read and sign the following statement:

MEDICAL PRACTITIONER'S STATEMENT

To the Health Care Provider:
Prior to approval for adoption, the physical and mental health of household members must be assessed to determine the health and safety of the child and quality of his/her care would not be adversely affected by the adoption. To assist in this matter, please complete this form based upon the information gathered during a recent exam with the above-named patient. If you wish to discuss the contents of this report, you may call the Adoption Specialist at (616) 632-5108. If there is no need to discuss the report, please return it to the patient.

In your opinion, are there any physical or mental factors that would jeopardize the physical or mental welfare of any child placed in this family for adoption? ☐ Yes ☐ No

Practitioner's Signature	Date	Practitioner's printed name
Address		Telephone Number

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize my health care professional to release to the Kent County Adoption Office or its agent's information regarding my physical condition, mental health, and/or substance abuse services. I understand that completion of this form is required for the agency to proceed with the adoption.

_____
Patient or Responsible Adult Signature and Date

PHYSICAL EXAMINATION
Kent County Circuit Court Adoption Department

Name	Date of Birth

TO BE COMPLETED BY LICENSED PHYSICIAN, PHYSICIAN'S ASSISTANT OR NURSE PRACTITIONER

Date of Physical Examination	Do you provide medical services to this individual: ☐ Regularly ☐ Occasionally ☐ First Time

1	Does this individual suffer from an illness including a communicable disease that would be detrimental to the care of an adoptive child place in his/her home?	☐ Yes	☐ No
2	Are there any chronic or serious disorders for which this individual has been or is receiving treatment?	☐ Yes	☐ No
3	Is this individual currently taking medication?	☐ Yes	☐ No
4	If yes, could this medication adversely affect his/her ability to care for or be around children?	☐ Yes	☐ No
5	Has this individual been tested for TB? ☐ Yes ☐ No If yes, Date:		
6	Is this individual experiencing any physical, behavioral, or emotional problems that would be detrimental to an adoptive child placed in the home?	☐ Yes	☐ No
7	Have you ever referred this individual to other medical services, mental health services or treatment of alcohol/substance abuse?	☐ Yes	☐ No

If the answer to any of the above questions is **YES**, please explain: _____

Height _____ Weight _____ Heart _____ Blood Pressure _____

Lungs _____ Vision _____ Hearing _____ General Appearance _____

LABORATORY TESTS

Tuberculin test and/or X-Ray	Date _____	Results _____
Hemoglobin	Date _____	Results _____
Urinalysis	Date _____	Results _____

PHYSICIAN'S REMARKS ON HISTORY _____

PRACTITIONER'S STATEMENT

In your opinion, are there any physical or mental factors that would jeopardize the physical or mental welfare of any child placed in this family for adoption? ☐ Yes ☐ No

Would you like to be contacted by the adoption worker regarding your recommendation? ☐ Yes ☐ No

Practitioner's Signature	Date	Practitioner's Printed Name	License Number

Address	Telephone Number

MEDICAL STATEMENT FOR ADOPTION

To be Completed for Adoptive Parent (Petitioner 1)
Kent County Circuit Court Adoption Department

Patient Information (to be completed by patient or responsible adult)

Name	Relationship	Date of Birth

Address (Street, City, State, Zip)

Are you currently taking any medication? If yes, please list medications and reason for use _____

Have you ever been treated for any of the following? (check all that apply)

☐ Heart Disease	☐ Kidney Disease	Cancer	Diabetes
☐ Emphysema	☐ Epilepsy	Tuberculosis	
☐ Alcohol Abuse	☐ Substance Abuse	Mental Health Issues	
☐ Current Communicable Disease		Other Serious or chronic illness	

If any are checked, please explain _____

If you <u>have</u> checked any of the above, please have page 2 of this form completed by your licensed physician, physician's assistant, or nurse practitioner.

If you <u>have not</u> checked any of the above, please have your licensed physician, physician's assistant or nurse practitioner read and sign the following statement:

MEDICAL PRACTITIONER'S STATEMENT

To the Health Care Provider:
Prior to approval for adoption, the physical and mental health of household members must be assessed to determine the health and safety of the child and quality of his/her care would not be adversely affected by the adoption. To assist in this matter, please complete this form based upon the information gathered during a recent exam with the above-named patient. If you wish to discuss the contents of this report, you may call the Adoption Specialist at (616) 632-5108. If there is no need to discuss the report, please return it to the patient.

In your opinion, are there any physical or mental factors that would jeopardize the physical or mental welfare of any child placed in this family for adoption? ☐ Yes ☐ No

Practitioner's Signature	Date	Practitioner's printed name

Address	Telephone Number

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize my health care professional to release to the Kent County Adoption Office or its agent's information regarding my physical condition, mental health, and/or substance abuse services. I understand that completion of this form is required for the agency to proceed with the adoption.

_____
Patient or Responsible Adult Signature and Date

PHYSICAL EXAMINATION
Kent County Circuit Court Adoption Department

Name	Date of Birth

TO BE COMPLETED BY LICENSED PHYSICIAN, PHYSICIAN'S ASSISTANT OR NURSE PRACTITIONER

Date of Physical Examination	Do you provide medical services to this individual: ☐ Regularly ☐ Occasionally ☐ First Time

1	Does this individual suffer from an illness including a communicable disease that would be detrimental to the care of an adoptive child place in his/her home?	☐ Yes	☐ No
2	Are there any chronic or serious disorders for which this individual has been or is receiving treatment?	☐ Yes	☐ No
3	Is this individual currently taking medication?	☐ Yes	☐ No
4	If yes, could this medication adversely affect his/her ability to care for or be around children?	☐ Yes	☐ No
5	Has this individual been tested for TB? ☐ Yes ☐ No If yes, Date:		
6	Is this individual experiencing any physical, behavioral, or emotional problems that would be detrimental to an adoptive child placed in the home?	☐ Yes	☐ No
7	Have you ever referred this individual to other medical services, mental health services or treatment of alcohol/substance abuse?	☐ Yes	☐ No

If the answer to any of the above questions is **YES**, please explain: _____

Height _____ Weight _____ Heart _____ Blood Pressure

Lungs _____ Vision _____ Hearing _____ General Appearance _____

LABORATORY TESTS

Tuberculin test and/or X-Ray	Date	_____	Results	_____
Hemoglobin	Date	_____	Results	_____
Urinalysis	Date	_____	Results	_____

PHYSICIAN'S REMARKS ON HISTORY _____

PRACTITIONER'S STATEMENT

In your opinion, are there any physical or mental factors that would jeopardize the physical or mental welfare of any child placed in this family for adoption? ☐ Yes ☐ No

Would you like to be contacted by the adoption worker regarding your recommendation? ☐ Yes ☐ No

Practitioner's Signature	Date	Practitioner's Printed Name	License Number

Address	Telephone Number

MEDICAL STATEMENT FOR ADOPTION

To be Completed for Adoptive Parent (Petitioner 2)
Kent County Circuit Court Adoption Department

Patient Information (to be completed by patient or responsible adult)

Name	Relationship	Date of Birth

Address (Street, City, State, Zip)

Are you currently taking any medication? If yes, please list medications and reason for use _____

Have you ever been treated for any of the following? (check all that apply)

☐ Heart Disease ☐ Kidney Disease ☐ Cancer ☐ Diabetes
☐ Emphysema ☐ Epilepsy ☐ Tuberculosis
☐ Alcohol Abuse ☐ Substance Abuse ☐ Mental Health Issues
☐ Current Communicable Disease ☐ Other Serious or chronic illness

If any are checked, please explain _____

If you <u>have</u> checked any of the above, please have page 2 of this form completed by your licensed physician, physician's assistant, or nurse practitioner.

If you <u>have not</u> checked any of the above, please have your licensed physician, physician's assistant or nurse practitioner read and sign the following statement:

MEDICAL PRACTITIONER'S STATEMENT

To the Health Care Provider:
Prior to approval for adoption, the physical and mental health of household members must be assessed to determine the health and safety of the child and quality of his/her care would not be adversely affected by the adoption. To assist in this matter, please complete this form based upon the information gathered during a recent exam with the above-named patient. If you wish to discuss the contents of this report, you may call the Adoption Specialist at (616) 632-5108. If there is no need to discuss the report, please return it to the patient.

In your opinion, are there any physical or mental factors that would jeopardize the physical or mental welfare of any child placed in this family for adoption? ☐ Yes ☐ No

Practitioner's Signature	Date	Practitioner's printed name

Address	Telephone Number

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize my health care professional to release to the Kent County Adoption Office or its agent's information regarding my physical condition, mental health, and/or substance abuse services. I understand that completion of this form is required for the agency to proceed with the adoption.

_____
Patient or Responsible Adult Signature and Date

PHYSICAL EXAMINATION
Kent County Circuit Court Adoption Department

Name	Date of Birth

TO BE COMPLETED BY LICENSED PHYSICIAN, PHYSICIAN'S ASSISTANT OR NURSE PRACTITIONER

Date of Physical Examination	Do you provide medical services to this individual: ☐ Regularly ☐ Occasionally ☐ First Time

1	Does this individual suffer from an illness including a communicable disease that would be detrimental to the care of an adoptive child place in his/her home?	☐ Yes	☐ No
2	Are there any chronic or serious disorders for which this individual has been or is receiving treatment?	☐ Yes	☐ No
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6	Is this individual experiencing any physical, behavioral, or emotional problems that would be detrimental to an adoptive child placed in the home?	☐ Yes	☐ No
7	Have you ever referred this individual to other medical services, mental health services or treatment of alcohol/substance abuse?	☐ Yes	☐ No

If the answer to any of the above questions is **YES**, please explain: _____

Height _____ Weight _____ Heart _____ Blood Pressure _____

Lungs _____ Vision _____ Hearing _____ General Appearance _____

LABORATORY TESTS

Tuberculin test and/or X-Ray	Date	_____	Results	_____
Hemoglobin	Date	_____	Results	_____
Urinalysis	Date	_____	Results	_____

PHYSICIAN'S REMARKS ON HISTORY _____

PRACTITIONER'S STATEMENT

In your opinion, are there any physical or mental factors that would jeopardize the physical or mental welfare of any child placed in this family for adoption? ☐ Yes ☐ No

Would you like to be contacted by the adoption worker regarding your recommendation? ☐ Yes ☐ No

Practitioner's Signature	Date	Practitioner's Printed Name	License Number

Address	Telephone Number

17th Judicial Circuit Court for the County of Kent

Adoption Department

Reference Letter

This form is to be completed legibly, print or type. If certain areas do not apply, print or type N/A.
[Use Tab after each line to go to the next line]

Adoptee(s) birth name(s)**:** _____

Your name: _____ Age: _____

Relationship to adoptive parent(s) _____

1. How long have you known the adoptive parent(s)? _____
2. How would you describe adoptive parent(s) relationship with the child(ren)? _____

3. How would you describe adoptive parent(s) parenting style? _____

4. Do you believe the adoptive parent(s) are able to fulfill the child's(ren's) intellectual, spiritual and moral development? ☐ Yes ☐ No
5. Can the adoptive parent(s) provide a safe and nurturing environment for the child(ren) to grow and develop? ☐ Yes ☐ No
6. Do the adoptive parent(s) live in and maintain a clean and adequate home environment? ☐ Yes ☐ No
7. Are the adoptive parent(s) active in the community, how? _____

8. What are some recreational activities the adoptive family is known to be involved in? _____

17th Judicial Circuit Court for the County of Kent

Adoption Department

Reference Letter

This form is to be completed legibly, print or type. If certain areas do not apply, print or type N/A.
[Use Tab after each line to go to the next line]

9. Are you aware of any health conditions of adoptive parent(s)? ☐ No ☐ Yes (If yes, explain):

_____

_____

If yes to question #9, is the person with the health condition(s) able to meet the needs of the adoptee?

(Explain)**:** _____

_____

10. Are you aware of any prior substance use issues of adoptive parent(s)? ☐ No ☐ Yes (If yes, explain):

_____

_____

If yes to question #10, does the parent's prior substance use impede his/her ability to adopt? (Explain):

_____

_____

11. Would you recommend the adoptive parent(s) for adoption of the child(ren)?

_____

_____

_____

_____

_____

Signature _____ Date:_____

09/13/2021 HH

17th Judicial Circuit Court for the County of Kent

Adoption Department

Reference Letter

This form is to be completed legibly, print or type. If certain areas do not apply, print or type N/A.
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Adoptee(s) birth name(s)**:** _____

Your name: _____ Age: _____

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8. What are some recreational activities the adoptive family is known to be involved in? _____

17th Judicial Circuit Court for the County of Kent

Adoption Department

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9. Are you aware of any health conditions of adoptive parent(s)? ☐ No ☐ Yes (If yes, explain):

_____

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If yes to question #9, is the person with the health condition(s) able to meet the needs of the adoptee?

(Explain)**:** _____

_____

10. Are you aware of any prior substance use issues of adoptive parent(s)? ☐ No ☐ Yes (If yes, explain):

_____

_____

If yes to question #10, does the parent's prior substance use impede his/her ability to adopt? (Explain):

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_____

11. Would you recommend the adoptive parent(s) for adoption of the child(ren)?

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_____

Signature _____ Date:_____

09/13/2021 HH

17th Judicial Circuit Court for the County of Kent

Adoption Department

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[Use Tab after each line to go to the next line]

Adoptee(s) birth name(s)**:** _____

Your name: _____ Age: _____

Relationship to adoptive parent(s) _____

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17th Judicial Circuit Court for the County of Kent

Adoption Department

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If yes to question #9, is the person with the health condition(s) able to meet the needs of the adoptee?

(Explain)**:** _____

_____

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_____

If yes to question #10, does the parent's prior substance use impede his/her ability to adopt? (Explain):

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_____

11. Would you recommend the adoptive parent(s) for adoption of the child(ren)?

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_____

_____

_____

_____

Signature _____ Date:_____

09/13/2021 HH