



HELPUSADOPT.ORG GRANT APPLICATION

PLEASE DO NOT RETYPE THIS APPLICATION. EACH QUESTION MUST BE FILLED IN COMPLETELY. If question is not applicable to you, please mark N/A. If you leave a question blank your application will be considered incomplete.

1. Date

2. Applicant #1 : Name/DOB
Applicant #2: Name/DOB

3. Address

4. Email

5. Phone: Home/Cell

6. Number of children in your immediate family

7. Have you ever adopted before? If yes, please include information in your personal statement.

8. Is anyone in your immediate family adopted, an adoptive parent or connected with adoption in any way?
If yes, please explain.

9. Applicant #1: Employer/occupation/title
Applicant #2: Employer/occupation/title

10. Does your employer have adoption benefits? If yes, please explain.
Applicant #1

Applicant #2



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11. What were your earnings in the past two years? Please list each year separately.

Applicant #1

Applicant #2

12. What are you projected earnings for the current year?

Applicant #1

Applicant #2

13. What is your current total balance of savings and checking accounts?

Savings _____ Checking _____

14. What is the net worth of your retirement/IRA savings plan?

Applicant #1

Applicant #2

15. Do you own any stocks or bonds or have any other investments? If yes, please indicate the total portfolio value.

16. Do you rent or own your living space? If you rent, what is your monthly rent payment?

17. If you own your home, what is the fair market value of your home?

18. Do you own/rent any other real estate properties or timeshares? If yes, please describe and give fair market value.

19. If you answered YES to #18, are any of the properties used as vacation rental properties that generate income? If yes, please give details including amounts.

20. Approximately how much consumer debt do you have? Please itemize in the following categories:

a) Mortgage balance/Monthly payment

b) Credit Card Debt and Monthly Payment (*If you have significant credit card debt please explain the nature of this debt.*)

c) Car/Truck loan(s)

d) Student Loans (*If you have significant student loans please explain the nature of this debt*)

e) Other (*Please specify*)



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21. Do you either pay or receive alimony or child support? If yes, please give brief explanation including amounts.

22. Please itemize your total adoption expense and indicate what you have paid so far and what is outstanding. If more space is used PLEASE use a separate sheet of paper.

23. How have you paid for your adoption expenses this far and how do you intend to pay for the balance?

24. Please specify the amount you are looking to receive from \$500 - \$15,000. MUST SPECIFY AMOUNT.

25. Are you applying for any other grants, loans or financial assistance? If yes, please explain and give amounts.

26. Please indicate if you have received any of the aforementioned grants.

27. Adoption placement agency, caseworker or lawyer name, including their address and phone number.

28. How did you hear about Helpusadopt.org?

29. Personal Statement.

Please answer questions below in a TYPED personal statement. *Limit 2500 words or less.*

a. Are there any needs/special considerations you would like the grant selection committee to know about?

b. If applicable please explain your experience with adoption.

c. What has inspired you to build your family through adoption?

SELECTION PROCESS POLICIES:

- **Grants will be awarded** in June and December, annually.
- **Applications must be postmarked** by Friday October 16, 2009 for December 2009 Grants and Friday April 16, 2010 for June 2010 Grants.
- **Family members and close personal friends, connections of the board** are prohibited from applying for grants.
- The Helpusadopt.org co-founders will review all applications including homestudies and personal statements. Those complete applications that meet all of the aforementioned criteria and exhibit the greatest financial need, significant obstacles and hardships will be presented to and reviewed by the grant committee for final selection.
- Grant recipients will be notified via mail and telephone. All applicants will receive notification via mail. June Grants will be notified by June 15th and December Grants will be notified by December 15th.
- Due to the volume of applicants, please do not call to follow up on your application or to be sure that we received it. If there are any problems with your application we will contact you directly.
- Grant committee will make final decisions based on a case-by-case basis based on the information provided in both the application and personal statement.
- **Grants will be awarded in amounts varying from \$500 - \$15,000.** Checks in the awarded amount will be written out and mailed directly to service providers.
- **Grants must be utilized within 12 months of the awarded date.** If recipient does not use the money then it will go back to Helpusadopt.org and will be redistributed in the next grant cycle.
- If at anytime recipient terminates adoption plans (*for example: due to natural pregnancy, divorce*) the remaining grant money will be forfeited and will return to Helpusadopt.org for future distribution.
- Applicants may apply annually but may only receive one grant.
- Helpusadopt.org will not reimburse completed adoptions.
- **All US citizens can apply.** Qualified applicants will not be judged on marital status, race, religion, sexual orientation or national origin.

PLEASE SIGN WHERE INDICATED:

Applicant #1 Signature

Applicant #1 Print Name

Applicant #2 Signature

Applicant #2 Print Name

By signing this application I/we acknowledge that all of the information provided in this grant application is truthful and accurate. I/we understand, authorize and agree that our complete application (including home study and personal statement, which may include personal identifying information and personal medical information) will be reviewed by the co-founders, grant selection committee and possibly the board of directors of Helpusadopt.org. Additionally, I/we authorize Helpusadopt.org to contact all of our service providers that we have listed on our behalf to clarify or verify any of the information provided.



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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Because your home study may contain medical information and the Federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) protects patients from the unauthorized use or disclosure of protected health information about them, we request that all applicants sign his Authorization which allows Helpusadopt.org to use and disclose your protected health information according to the terms herein.

APPLICANT #1 NAME / DOB: _____

APPLICANT #2 NAME / DOB: _____

ADDRESS (including zip code): _____

I authorize the use and disclosure of my Protected Health Information according to the terms herein. I understand that only persons or entities having rights under this Authorization may use and disclose my Protected Health Information in accordance with this Authorization.

A. Persons authorized to disclose and receive Protected Health Information: I authorize any physician, physician practice group, dentist, hospital, nurse, medical laboratory, health plan and any other health care provider, health insurance issuer or agent, affiliate, or broker of any of the aforementioned (collectively “Providers”) possessing any past, current, or future medical records, including, but not limited to, physical or mental health information, (collectively “Protected Health Information”) to disclose to Helpusadopt.org (“HUA”), its agents, affiliates, independent contractors, service providers or other representatives (collectively “Recipient”) any and all such Protected Health Information as requested by HUA. This Authorization permits and authorizes the disclosure, inspection, and copying of any and all records, reports and/or documents that contain my Protected Health Information, including, but not limited to, any and all medical charts, clinical or doctors’ notes (excluding psychotherapy notes), memoranda, radiology, pathology, or test reports, index cards, history notes, mental health records, pictures, patient management records, claims records, payment for the provision of healthcare and medical bills.

B. Purpose of this Authorization: I understand that the information obtained pursuant to this Authorization will be used by Recipient to determine whether to approve my grant application. Except as permitted by this Authorization, no Recipient will release any information obtained pursuant to this Authorization to any person or organization except: (1) pursuant to this Authorization, or (2) as may otherwise be lawfully required, or (3) as I may further authorize.

C. Expiration: I agree that this Authorization shall remain valid and enforceable for one year from the date of execution or until this Authorization is completely revoked by me, unless earlier terminated by applicable law. I understand that I may partially revoke this Authorization with respect to particular Recipients and this will not affect any other Recipient’s rights hereunder.

D. Voluntariness of the Authorization: I understand that my signature and approval of this Authorization and its contents is voluntary, however I understand that Recipient will not be able to properly administer my grant application without my signature and disclosures. I further understand that I will not be denied any medical treatment for my failure to sign this Authorization. Revocation of this Authorization must be made in writing to HUA and shall be effective immediately upon HUA’s receipt of my revocation. However, revocation does not terminate any Recipient’s ability to use my Protected Health Information already collected and will not be effective to the extent that a third party has taken action in reliance on this Authorization for a use or disclosure of my Protected Health Information prior to receiving my revocation.

E. Reuse and Re-disclosure: I understand that disclosure of Protected Health Information to a Recipient pursuant to this Authorization may result in the disclosure of my Protected Health Information to third parties who are not covered by state or federal privacy law. In this case, I understand that my Protected Health Information may not be protected by the HIPAA Privacy Regulations and as a result may be subject to redisclosure by the Recipient and furthermore is no longer protected by federal or state privacy laws.

BY SIGNING THIS AUTHORIZATION FOR RELEASE OF MY PROTECTED HEALTH INFORMATION, I UNDERSTAND AND AGREE TO THE STATEMENTS CONTAINED HEREIN AND AUTHORIZE THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED HEREIN.

Applicant #1 Signature

Date

Applicant #2 Signature

Date