ADOPTION ASSISTANCE REIMBURSMENT FORM

This form is an adoption expense reimbursement claim form.
See the BOC Employee Handbook for policy.

Instructions to Employee: Please complete all sections and attach a copy of the receipts and cancelled checks for all expenses listed in Section C as well as a copy of the adoption placement decree and birth certificate. Attach a separate sheet of paper for additional expenses (if necessary). Keep a copy of this form and all attachments. The documents you submit will not be returned to you.

SECTION A: Employee Information

Employee Name:	Title:	
Agency:	Employee ID #:	Date of Hire:
Address:	City/State:	Zip:
Home Phone:	Daytime Phone:	
Spouse/Partner Name:	Spouse/Partner Employer:	

SECTION B: Child's Information

(Attach an extra sheet if adopting more than one child at the same time)

Child's Name:	Date of Birth:	Social Security # (if known):
Is the child in your home: Yes ☐ No ☐	Date Adoption Finalized:	State or Country where adoption finalized:

SECTION C: Eligible Adoption Expense Information

(Attach supporting documentation such as detailed receipts or invoices, cancelled checks or other proof of payment)

Eligible Expenses:

- *Required medical expenses for the child prior to adoption*
- *Temporary foster care expenses incurred prior to placement*
- *Immigration fees*
- *Attorney fees, other legal fees and court costs*
- *Medical expenses related to the child's birth*
- *Medical maternity expenses for the child's biological mother not covered by insurance*
- *Immunization costs*
- *Translation services*
- *Transportation and lodging expenses related to the adoption*

Date Incurred:	**Service Provider:** (Include name of person, organization or entity to which expense was paid)	**Amount:**
	Subtotal of expenses listed above:	
	Less amount of benefit applied for or received for this adoption: (from any other government or private agency, or any other source)	
	Total Expenses for Reimbursement: (not to exceed $5000 or $7000 for a special needs adoption)	

SECTION D: Certification

I certify that the receipts and cancelled checks I am submitting are qualified adoption expenses under the Board of Commissioners' Adoption Assistance Reimbursement Policy and that all statements and documentation relating to this claim are complete and true. I understand that it is my obligation to determine whether any payment made under the Adoption Assistance Reimbursement Program is excludable from my gross income for federal or state income tax purposes. Note: This reimbursement may be subject to employee/employer Medicare withholding taxes.

Employee's Signature:	Date:
Authorizing Signature:	Date: