



## Adoption Reimbursement Form

Complete the information below and submit this page along with itemized receipts and a copy of the adoption decree to your Human Resources Business Partner for reimbursement within one year of the date of adoption. Please use a separate form for each adoptee.

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_  
 Zip: \_\_\_\_\_  
 Name of Adopted Child: \_\_\_\_\_  
 Adopted Child's Date of Birth: \_\_\_\_\_  
 Date of Adoption: \_\_\_\_\_

**Adoption Expenses (Attach itemized receipts. Use additional forms as needed.)**

Adoption Expense Description	Amount

**Total** \_\_\_\_\_

By signing below, I certify that the following are true and correct:

1. I completed 12 continuous months of full-time (*i.e.*, not seasonal or temporary) service prior to incurring a reimbursable expense;
2. The adoptee was born prior to the adoption and was less than 18 years old at the time of adoption;
3. The adoption expenses in question are not eligible for payment or reimbursement through another benefit plan, such as a health insurance Plan or health care flexible spending account.

\_\_\_\_\_  
 Signature Date

**\*\*\*FOR HUMAN RESOURCES USE ONLY\*\*\***

\_\_\_\_\_  
 Approved By (signature) Printed Name

\_\_\_\_\_  
 Date