Adoption Assistance Reimbursement Request Form

Employee Information:

Employee Name_____ **ID Number**_____ **Bargaining Unit**_____

Department_____ **Job Title**_____

Home Address_____

City_____ **State**_____ **Zip Code**_____

Home Phone_____ **Work Phone**_____

Eligible Adoption Expenses:

Date Paid	Amount	Description
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Total Reimbursement: _____

Note: *Please attach receipts in U.S. dollars for all expenses listed above, as well as a copy of the adoption placement decree.
***Applicable federal, state and local taxes will be withheld from your reimbursement.**

Employee Request for Reimbursement:

I would like to apply for reimbursement of adoption expenses listed above, confirming that_____
(Child's name)
Whose birth date is_____, **was placed in my home for the purpose of adoption on**_____
(Date)
The Date for adoption finalization is_____.

I certify that this is a claim for allowable expenses under the University of Massachusetts Medical School adoption reimbursement program.

_____ _____
(Signature of employee) **(Date)**

_____ _____
(Approved) **(Date)**

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