

**APPLICATION FOR REIMBURSEMENT FOR  
NON-RECURRING ADOPTION EXPENSES**

**I. Adoptive Parents (s)**

|                             |                             |
|-----------------------------|-----------------------------|
| Mother's Name (Last, First) | Father's Name (Last, First) |
| Address                     | Telephone Number            |

**II. Adoptive Child**

|                            |                |
|----------------------------|----------------|
| Name (Last, First, Middle) |                |
| Date of Birth              | Place of Birth |

- What agency was named statutory parent for the purpose of placing this child into adoption?  
Department of Children and Families

- When did you or do you expect to adopt this child? June 2006

Are you receiving or applying for adoption assistance for this child from any other state?

☐ Yes ☐ No. If yes, please explain:

- Have you applied for or received reimbursement for adoption related expenses from any other source?  
☐ Yes ☐ No. If yes, please explain:

**III. Child's Status**

☐ The child cannot be placed without assistance due to: (If DCF adoption, attached DCF-416 and required documentation. If a private agency adoption, please check below.)

- ☐ Age
- ☐ Membership in an ethnic or racial minority  
What Minority group: \_\_\_\_\_
- ☐ Placed in you home with biological siblings
- ☐ Medical condition or physical handicap
- ☐ Mental or emotional handicap

Documentation is attached substantiating the child's medical or handicapping condition from a physician or psychiatrist.

☐ The child cannot or should not return home to biological parents because parental rights have been terminated. A copy of the order terminating parental rights is attached as verification.

☐ Documentation is attached that attempts were made to place him/her without adoption assistance, unless contrary to the child's best interest.

*(Please note that without documentation on the conditions outlined above, eligibility for this program cannot be granted.)*

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**IV. Request for Reimbursement**

I/We request reimbursement for the following non-recurring adoption expenses. I/We certify that these expenses are expenses that I/We are required to pay. *(Please attach copies of bill.)*

| <u>Expense</u> | <u>Cost</u> |
|----------------|-------------|
| <hr/>          | <hr/>       |
| <hr/>          | <hr/>       |
| <hr/>          | <hr/>       |
| <hr/>          | <hr/>       |
| <hr/>          | <hr/>       |

**V. Release of Information**

I/We give permission to the Department of Children and Families to obtain information from the following persons or agencies in order to verify information needed to determine eligibility for this reimbursement for non-recurring expenses related to the adoption. Please list any person or agency that can verify information provided in Section III.

| Name/Agency | Address | Telephone Number |
|-------------|---------|------------------|
| <hr/>       | <hr/>   | <hr/>            |
| <hr/>       | <hr/>   | <hr/>            |
| <hr/>       | <hr/>   | <hr/>            |

**VI. Certification**

I/We certify that the information provided above is true to the best of my/our knowledge.

|                             |                        |       |
|-----------------------------|------------------------|-------|
| Adoptive Mother's Signature | Social Security Number | Date  |
| <hr/>                       | <hr/>                  | <hr/> |
| Adoptive Father's Signature | Social Security Number | Date  |
| <hr/>                       | <hr/>                  | <hr/> |

Please return this application, with the required documentation to: **(Social Worker name)**